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ABSTRACT

This technical report examines the literature on substance abuse prevention programs among American Indian and Alaska Native populations, particularly high-risk youth, and reports on aspects of demonstration projects. The literature was reviewed for specific mention of attempted intervention activities focusing on alcohol and drug abuse prevention or related risk factors. Sixty strategies were identified and are described within the categories of: (1) historically significant programs; (2) programs targeting pregnancy and early child care; (3) programs targeting youth in foster care; (4) programs targeting Indian boarding school and public school populations; (5) community-based programs for youth; (6) residential programs for youth; (7) cultural enhancement for youth in the community; (8) programs within behavioral health clinics; and (9) intervention program planning. Most programs were promotional and primary in nature; educational and training activities predominated. Synopses of 16 Office for Substance Abuse Prevention grantee projects are presented, focusing on primary, secondary, and tertiary prevention strategies. Managers of these demonstration projects were surveyed by telephone about program philosophy and beliefs, project characteristics, specific strategies, organizational structure and management, and evaluation. With the exception of rigorous evaluation, the projects showed moderate to strong adherence to factors associated with the success of prevention programs in general. This report contains 92 references, the survey instrument, and tables summarizing prevention activities. (SV)

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Office for Substance Abuse Prevention

Breaking New Ground For American Indian And Alaska Native Youth At Risk: Program Summaries

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OSAP Technical Report–3

Breaking New Ground For American Indian And Alaska Native Youth: Program Summaries

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OSAP Technical Reports are prepared by the Division of Demonstrations and Evaluation, Office for Substance Abuse Prevention (OSAP), and published by its Division of Communication Programs. The primary objective of the series is to facilitate the transfer of prevention and intervention technology between and among researchers, administrators, policymakers, educators, and providers in the public and private sectors. At times, this series will publish reviews of innovative or exemplary programming models and reviews of evaluative studies conducted by OSAP grantees.

This publication was prepared by the National Center for American Indian and Alaska Native Mental Health Research, Department of Psychiatry, School of Medicine, the University of Colorado Health Sciences Center, Denver, Colorado 80262. The editors for this technical report were Eric N. Goplerud and Hank Resnik. Funding for this project was provided under contract number 88 M 075606501 D from the Office for Substance Abuse Prevention.

The term "alcohol and other drugs" used herein includes inhalants. The section entitled "OSAP Demonstration Project Survey" uses the term "substance abuse" throughout. This was the appropriate terminology when the survey was conducted. However, the term has since been replaced by the use of "alcohol and other drugs."

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Project Officer
Eric N. Goplerud, Ph.D.

OSAP Technical Report Series
Elaine M. Johnson, Ph.D.
Director, OSAP

Bernard R. McColgan
Director, Division of Demonstrations and Evaluation

Robert W. Denniston
Director, Division of Communication Programs

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Candace M. Fleming, Ph.D. Spero M. Manson, Ph.D. Christine Duclos, M.P.H. Alice Castillo, B.A.	National Center for American Indian and Alaska Native Mental Health Research University of Colorado Health Sciences Center
Fred Beauvais, Ph.D.	Western Behavioral Studies Colorado State University
Gregory Cornell, M.S.	Northwest Research Office Columbia University School of Social Work
Joyce M. Kramer, Ph.D.	Department of Behavioral Sciences University of Minnesota, Duluth
Carol Lujan, Ph.D.	School of Justice Studies Arizona State University
Philip A. May, Ph.D.	Department of Sociology University of New Mexico
Valerie C. Montoya, Ph.D.	Department of Behavioral Sciences and Human Behavior University of Alaska at Fairbanks
Joseph E. Trimble, Ph.D.	Department of Psychology Western Washington University

Special recognition is offered to the many OSAP grantees who participated and contributed to the development of this technical report.

Foreword

The Office for Substance Abuse Prevention (OSAP) is particularly pleased to present this third in a series of technical reports. It offers a state-of-the-art portrayal of alcohol and other drug issues and programs among an important population: American Indian and Alaska Native youth. It summarizes 16 demonstration grants that provide promising prevention models for working with these youth and also reviews 80 articles identifying over 60 prevention interventions. As these summaries and articles demonstrate, many exciting approaches are being offered across the United States focusing on this youth group.

Among the programs described, cultural considerations are especially prevalent, as well as concern for OSAP's two key target groups: youth and pregnant and postpartum women and their infants. Variables that have been incorporated into these programs include historical implications, familial patterns, educational environments, social patterns and environments, and patterns of use of alcohol and other drugs. We believe these programs have broken new ground and have also created a hopeful climate for continued efforts among this population.

OSAP's technical report series is designed to provide indepth, practical information about successful prevention activities, making available the most current and reliable information about effective strategies and techniques. In addition to reporting the latest findings from the field, OSAP hopes to answer many of the questions practitioners have about the realistic aspects of developing programs for those at high risk, including guidelines for selecting, recruiting, and retaining hard-to-reach youth for prevention activities.

OSAP is an agency of the Alcohol, Drug Abuse, and Mental Health Administration within the Department of Health and Human Services. It has been given a lead role in the Nation's effort to reduce the demand for and to prevent problems caused by the abuse of alcohol and other drugs, as mandated by Congress in the Anti-Drug Abuse Acts of 1986 and 1988. Within this mandate, OSAP promotes partnerships with and between public- and private-sector organizations and agencies. OSAP believes such partnerships are the critical element for undertaking the comprehensive approach necessary to reduce alcohol and other drug problems in the United States today.

This technical report continues to foster the networking process by sharing new knowledge about programs for those in high-risk environments and by promoting the most effective approaches to the challenges we face.

Elaine M. Johnson, Ph.D.
Director
Office for Substance Abuse Prevention

Preface

This review of literature and programs pertaining to the prevention of alcohol and other drug problems among American Indians and Alaska Natives is an important milestone for the Office for Substance Abuse Prevention (OSAP), which currently funds 18 programs in such communities in 12 States. Much can be learned from these programs that should prove useful to the health and prevention fields.

This technical report begins with a detailed review of the literature, including a glimpse of the historical context. This overview of different types of programming can be useful in understanding the background for the current OSAP-funded effort in American Indian communities. At a glance, we can see what types of programs and approaches have been implemented over a period of several decades.

A systematic analysis of the current grantees' programs as outlined in their proposals follows. Then the report presents the results of a detailed process of telephone interviews and site visits conducted when most of the programs were well into their first year of implementing their OSAP grants. It concludes with a set of important recommendations for further action and study regarding prevention programming for American Indians and Alaska Natives.

The report makes several points clear. Most important, we are at a point where much has been done in American Indian and Alaska Native communities, much is known about what does and does not work, and the parameters for future study can be clearly defined.

OSAP's mission has been significantly aided and advanced by the work that went into this publication. We are enthusiastic about sharing this technical report with the field.

Bernard R. McColgan
Director
Division of Demonstrations and
Evaluation

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Executive Summary

The Drug Problem Among Indian/Native Youth

Although alcohol and other drug use has declined among American Indian and Alaska Native youth, as with the youth population generally, available findings indicate that more Indian youth use virtually every type of drug with greater frequency than non-Indians. This is particularly true for alcohol, marijuana, and inhalants. Also, the age of first involvement with alcohol is younger for Indian youth, the frequency and amount of drinking are greater, and the negative consequences are greater. As adolescents, Indian youth are more likely than others to use alcohol and other drugs in combination.

Although few satisfactory explanations exist for the higher rates of use for Indian youth, factors such as poverty, prejudice, and a lack of economic, educational, and social opportunities play a role. Among Indian youth, alcohol and other drug use appears to be related more directly to family influence than to peer influence. An important caveat is that most of these findings are drawn from studies of reservation youth, and much less is known about Indian youth in urban areas.

Literature Review

The literature reviewed for this report came from the National Center for American Indian and Alaska Native Mental Health Research. The center collects and indexes information about journal articles, books, dissertations, professional papers, and research reports on American Indian and Alaska Native behavioral health. Approximately 80 articles describing program activities and 60 prevention interventions were identified.

Programs were found in the following categories:

- *Programs with historic significance*, e.g., the Native American Indian Church, which stresses abstinence from alcohol use and the preservation of traditional cultural values; also, the Sweat Lodge and Sun Dance Rituals as culturally prescribed healing and health maintenance practices.
- *Programs targeting pregnancy and early child care*, e.g., child development courses for pregnant women and programs to prevent fetal alcohol syndrome.
- *Programs targeting youth in foster care*, e.g., incorporation of the traditional concept of the "Whipper Man" for maintaining discipline and well-being; also, alternatives to foster care.
- *Programs targeting Indian boarding school and public school populations*, e.g., intensive counseling and one-to-one support in residential settings; group therapy and group counseling for recent dropouts and students having problems; life skills/social competence training; and peer influence programs.
- *Community-based programs for youth*, e.g., positive alternatives, service opportunities, and peer counseling.
- *Residential programs for youth*, e.g., intervention and treatment activities.
- *Cultural enhancement for youth in the community*, e.g., tribal health fairs; education in traditional tribal arts, stories, and handicrafts; powwows and feasts; and culturally oriented family-strengthening programs for urban families.
- *Programs within behavioral health clinics*, e.g., teen centers, mental health centers, counseling, and a combination of traditional Indian values and group therapy techniques.

- *Intervention program planning*, e.g., planning to enhance cultural identity and empowerment as part of service delivery; also, formation of support groups and organizations such as the National Association for Native American Children of Alcoholics.

Most of the programs included in the review were promotional and primary in nature. Fifty-five percent of the 60 programs reviewed provided activities that could be classified as promotional. Education and training activities predominated (73 percent). More than half (58 percent) of the promotional programs had a sociocultural component. Twenty-seven percent provided recreational opportunities, and 24 percent provided consultation.

Summary of Program Proposals

The majority of the OSAP programs employed primary prevention strategies and approaches. Ninety-four percent of the projects provided some activities that could be classified as primary, 63 percent promotional, 50 percent secondary, and 50 percent tertiary. Social action, education/training, and cultural enhancement were the main promotional activities, included in 70 percent of the proposals. Recreational components were part of 60 percent of the projects. Primary interventions were mainly education/training (94 percent) and cultural activities (67 percent). Sixty percent provided consultation to schools, mental health agencies, and health clinics.

Secondary-level strategies focused mainly on assessment and referral, individual and group therapy, and self-help groups. As a whole, the OSAP-funded projects appeared to be identifying youth who are most at risk and providing them with services that will keep them from developing an entrenched alcohol- and other drug-using lifestyle. Tertiary interventions focused mainly on group and individual treatment.

Five of the 16 projects (31 percent) can be described as comprehensive—that is, they provided promotional, primary, secondary, and tertiary intervention techniques. Most of the others concentrated on primary and promotional interventions. Not surprisingly, cultural activities figured prominently in these projects.

Telephone Survey

A telephone survey to all the OSAP-funded sites covered five main topics: (1) program philosophy and beliefs, (2) descriptions of project characteristics, (3) descriptions of specific project strategies, (4) organizational structure and management, and (5) project evaluation. Highlights from the survey include the following findings:

- Poor self-esteem and parental alcoholism appear to be the most significant risks for substance abuse* (88 percent). Substance abuse by peers and friends follows, with 81 percent of the respondents indicating its importance.
- People with a defined spiritual belief system and/or positive self-esteem are thought to be least vulnerable to substance abuse/dependency (88 percent). Other protective factors considered important are being able to make decisions based on internal beliefs about personal responsibilities (69 percent) and/or to act independently (63 percent).
- Nearly all respondents (94 percent) believe that parents who model appropriate and healthy behavior are the best defense against substance abuse.
- The general intervention goals stressed most often are recognizing risk factors, increasing/enhancing program or community resources, promoting cultural identity, and promoting mental health (94, 88, 88, and 81 percent, respectively).
- Fifty percent of the programs were developed and are implemented by the tribe. The remaining half are operated by private/nonprofit corporations.
- The majority of the programs are community-based (63 percent), and all programs

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* "Substance abuse" is used throughout this section because the survey questions used that terminology.

have some community prevention activity. Ninety-four percent direct their activities to adolescents (13-19 years old), 69 percent to school-aged children (6-12 years old), and 50 percent to preschool children (4-5 years old).

- Eighty-seven percent of the programs target reservation communities, while two (13 percent) focus on urban populations.
- Ninety-four percent of the respondents use another agency for referrals, including schools.
- All but one of the programs is based to some degree on aspects of Indian/Native culture. Sixty-nine percent include cultural activities to a significant extent.

Conclusion

The OSAP projects reviewed by this study appear to be consistent with the current state of the art in substance use prevention among American youth in general. Although this is encouraging, the review also makes clear that further study and research are needed in a variety of key areas. As with the prevention field generally, program evaluation remains a weak area, and longitudinal research on program impacts is not only desirable but necessary.

The Nature and Extent of Alcohol and Other Drug Problems

This technical report examines the literature relating to programs to prevent alcohol and other drug problems among American Indian and Alaska Native populations, with an emphasis on high-risk youth. It presents the findings of a survey of the OSAP grantees serving these populations conducted in the fall of 1988. To understand the context for programs serving this population, however, it is important to understand the unique aspects of alcohol and other drug use among American Indians and Alaska Natives.

Epidemiological data about alcohol and other drug abuse among American Indians has been slowly emerging for both adults and youth, but more attention has been placed on studies of the youth. Important overviews that summarize these data are found in Oetting, Edwards, and Beauvais (in press), May (1982, 1989), and Austin (1989).

The available findings indicate that more Indian youth use virtually every type of drug with greater frequency than non-Indian youth (Beauvais and LaBoueff 1985; Beauvais et al. 1985*a*, 1985*b*; Oetting et al. 1988). Specifically, there is greater use of alcohol, marijuana, and inhalants among American Indian adolescents (grades 7 through 12), but less use of barbiturates (Oetting et al. 1980). According to Beauvais, Oetting, and Edwards (1985), the age at first involvement with alcohol is younger for Indian youths, the frequency and amount of drinking is greater, and the negative consequences are greater. A recent update on the Indian prevalence data (Beauvais et al. 1989) reiterates the higher rates of use for both male and female youth.

Moreover, once they enter adolescence, Indian youth are more prone than others to use alcohol and other drugs in combination (Oetting and Beauvais 1985). These trends continue into young adulthood. For example, Strimbu et al.'s study of over 20,000 U.S. college students revealed a higher level of drug involvement among American Indians than all other student groups. This finding was recently corroborated by Welte and Barnes (1987).

Alcohol and marijuana use are more common among American Indian youth; yet inhalant use is of equal concern because of its serious neuropsychological consequences. Oetting and Goldstein (1979) reported that inhalant use by Indians is almost twice as high at all ages from 12 to 17 as the U.S. averages. Between 9 and 11 percent of all youth from 12 to 19 years of age have used inhalants, but less than 1 percent use them regularly (Abelson et al. 1977; Ellinson et al. 1973). In a study of American Indian college students, Goldstein and his colleagues (1979) found that among students aged 18 to 27, 30 percent had tried inhalants. However, only 4 percent used them during the 2 months prior to interview, and none saw themselves as heavy users. Actual use of inhalants is highest in the early and middle teens and then tapers off in later years. It also appears to decline as other substances such as marijuana and alcohol become more accessible (Oetting and Goldstein 1979). Clearly, these inordinately high rates of inhalant use pose a significant health threat for this population (McBride 1980).

There is no clear explanation for the higher rates of use for Indian youth. It is generally speculated that the differences in rates are strongly linked to conditions that would make any group susceptible to alcohol and other drug use, i.e., poverty, prejudice, and lack of economic, educational, and social opportunity. A prevailing theory is that alcohol and other drug use by Indian youth is linked neither to emotional distress nor acculturation stress (Oetting et al. in press). Alcohol and other drug use appears to be related to peer drug associations, although less strongly than in Anglo youth, and is linked more directly than in Anglo youth to family influence.

In reviewing their decade of research on youth and drug use patterns, Oetting and associates (in press) also observed that drug use has declined among Indian youth as well as with other American youth. Whereas it is not clear if this trend is due to antidrug publicity, prevention interventions, general social change, and/or other factors yet to be defined, what is clear is that the youth who have been most susceptible to these influences are the light users. The rates for heavy users, who have a higher potential for dysfunction, have remained fairly constant in the past 10 years. Thus, there is a group of Indian youth who are most at risk for drug involvement and who are not being reached by alcohol and other drug interventions. The implications of these findings for prevention are that programs for Indian youth are critically needed, must be targeted to young children, and tertiary care (i.e., treatment) must be a vital part of the package.

Most of these findings, meager as they may be, derive from studies of alcohol and other drugs among reservation youth. Practically nothing is known about such behavior in urban areas, where living conditions are quite different (Trimble 1984). It is not surprising, then, that much of the ongoing preventive intervention programming in Indian/Native communities, rural and urban alike, proceeds in a virtual vacuum, left largely to trial and error.

In 1986, a questionnaire entitled the School/Community Based Alcohol/Substance Abuse Prevention Survey was conducted in Indian and Native communities nationally (Owan et al. 1987). The goals of the survey were to (1) determine the extent to which the schools/communities were involved in prevention activities; (2) seek vital information in areas regarding curricula, student/community/agency participation, intervention programs, and mass media programs; and (3) document the prevention activities that were tailored especially to reducing the risks of alcohol and other drug use in Indian and Native youth.

The survey was disseminated to Indian Health Service (IHS)-funded alcoholism programs at the local tribal levels, Bureau of Indian Affairs schools, public schools with large Indian youth enrollment, and public and private service providers. Nationally, 420 schools and 160 alcohol and other drug abuse programs (71 percent of all IHS-funded programs) participated in the survey.

The results of this survey indicated that an array of intervention and prevention activities have been developed and implemented along with treatment interventions in Indian and Native communities. There is much to suggest that many of the short- and long-term strategies used in these programs have replicability across tribal groups and regional areas, but that given the heterogeneity of the Indian and Native communities, the approaches will need to be modified to address each community's uniqueness. Further, ongoing research and evaluation are critically needed to determine the effectiveness of these prevention/intervention activities.

The survey's findings strongly suggested that interventions that attempt to enhance the health of Indian and Native families may be the most powerful in preventing and/or reducing the incidence of alcohol and other drug use among Indian youth. The key elements for success in early intervention programs appear to be program ownership by the community, collaboration with appropriate agencies, and implementation by the tribes to enhance the concept of self-determination. Also, the tremendous nationwide impact of the film, "The Honour of All," a documentary of the Alkali Lake Indian community's achievements, strongly advocates for the effective use of mass media in Indian and Native communities.

Discussions about Indian prevention programs seldom address administrative, political, and fiscal issues, all of which can determine the longevity of very effective programs that implement state-of-the-art technology. Future approaches to determine the effectiveness of prevention programs could include the construction of a "natural history," which highlights the conditions that lead to long-term survival or that seem to ensure program failure.

Given this background, the challenge of this technical report is to catalog the range of prevention activities that are being pursued in the communities, to identify those that may affect—directly or indirectly—the factors that place Indian youth at risk for using alcohol and other drugs, and to develop a framework for characterizing these activities that will facilitate their generalization across diverse settings. The first phase of this project and the topic of this technical report involves reviewing various literature to compile all published materials that speak to the prevention of alcohol and other drug use and the reduction of related risk factors, as outlined above, among Indian youth.

Literature Review

A review of the literature pertaining to programming for American Indians and Alaska Natives was a major focus of the research for this technical report. The bulk of relevant literature for review had already been located by the National Center for American Indian and Alaska Native Mental Health Research (the National Center) and its research associates. The National Center's bibliographic retrieval system collects and indexes information about journal articles, books, dissertations, professional papers, and research reports on American Indian and Alaska Native behavioral health. A similar effort by the National Center to identify effective prevention strategies directed at suicide and its related risk factors was an important resource.

The literature was examined for specific mention of tried intervention activity focusing on alcohol and other drug prevention or related risk factors. Much of the research discussed broad program suggestions and recommendations, and the references to actual delivery of prevention intervention often lacked detail and completeness. Nonetheless, from these approximately 80 articles designating program activity, 60 prevention interventions were identified.

These interventions are described in terms of public health prevention strategies or subtypes—promotional, primary, secondary, and tertiary—as they apply to alcohol and other drug use and abuse.

For our purposes, alcohol and other drug abuse and mental health *promotional* intervention is defined as an application to an entire population as opposed to a chosen risk group (e.g., dropouts). Health promotion and enhancement involve building or augmenting adaptive strengths, coping resources, survival skills, and general health. The goal is to reduce the prevalence of disease or disorder in a given population.

Primary activity is directed at a special subgroup in danger of manifesting alcohol and other drug abuse and, based on an analysis of risk factors, attempts to manipulate one or more conditions to forestall the occurrence of the disease in question. Health protection techniques are also primary prevention, and these employ regulatory and legislative action to reduce the probability that the disease agent and host will come into contact. Four legal strategies are described: establishing the conditions of contact (availability), deterring undesired behavior through punishment, symbolizing an official posture toward the behavior, and influencing the content of messages in the mass media.

Targeting those who have shown a developing pattern of alcohol and other drug abuse, *secondary* intervention entails early case finding and treatment. A reduction in the duration of a case consequently decreases the total number of active cases at any given point in time.

The degree of disability and further deterioration of a condition well established through prior abuse is addressed by *tertiary* prevention. The most common approach is rehabilitation complemented by community support programs to reduce the need for institutionalization.

Focusing on these strategies, the interventions are organized by actual programmatic activities—referral services, individual counseling/psychotherapy, group counseling/psychotherapy, self-help groups, social action, education/training, recreation, sociocultural, consultation, register, legal, and special facility. Only activities that were specifically mentioned in the writings were considered. Assumptions were not made about activities that could be inferred from the wide use of the phrase "comprehensive substance abuse or mental health services" found in the literature.

The following descriptions summarize, as of 1988, most published accounts of preventive intervention activities that focus on alcohol and other drug abuse and/or related risk factors among Indian/Native persons. The program/project names may not be official, but for purposes of this report, were assigned in the absence of a designated title to facilitate discussion. Programs that function in similar ways are grouped together, beginning with those that have historic significance and ending with those that target the Indian and Native community with prevention interventions.

Programs with Historic Significance

Handsome Lake Cult and False Face Society of the Iroquois

Referenced in: Dozier 1966; Wallace 1952, 1959; and Hall 1983.

Some of the earliest attempts to intervene and prevent alcohol and other drug abuse occurred among the Iroquois communities in the period 1799-1900. The founder of the cult, Handsome Lake, began his recovery from alcoholism after receiving visions in which he was instructed to embark on a mission to preach about the evils of alcohol, among other social messages. The activities of his religion had strong tertiary elements in that he acted as a shaman for individuals and groups in treating the disease. He promoted the ritual of public confessions, and much of his therapy relied on repressive disciplinary measures. His evangelistic appeal to the entire community in practicing appropriate social mores is an example of the promotional interventions that served as a foundation of this movement.

Native American Indian Church

Referenced in: Dozier 1966; Albaugh and Anderson 1974; Bergman 1971; Albaugh 1973; Pascarosa et al. 1976; Pascarosa and Futterman 1976; and Hall 1983.

This religion, introduced to Southwest tribes by Mexican natives around 1870, has elements of all four levels of prevention. The doctrine stresses abstinence from alcohol use as well as other values that promote health and wellness. The preservation of cultural values is emphasized along with the development of a strong social support system for the individuals practicing the religion. One-to-one counseling relationships can be established as a tertiary intervention and the group meetings, in which members are encouraged to express thoughts and feelings, are considered by some as a viable therapeutic tool for those recovering from alcoholism and other mental/physical disorders.

Ghost Dance Movement

Referenced in: Dozier 1966; and Hall 1983.

Ghost Dance was a brief nativistic movement that began in 1890 among western plains tribes. The followers expected a miraculous release from their current conditions, chief of which was the devastation of alcohol and other drug abuse, and expected an immediate restoration of the previous cultural ways. The promotional prevention strategy portrayed alcoholism as an evil symbol of Euroamerican culture and offered a revival of native traditions as an antidote.

Indian Shaker Church

Referenced in: Hall 1983.

Aspects of this church, which was founded in the late nineteenth century, can be considered representative of community-based primary prevention in that its message called for personal reform and abstinence from alcohol.

Prohibition

Referenced in: Dozier 1966; Stewart 1964; Back 1981; and May and Smith 1988.

The prohibition of liquor sales and liquor consumption on reservation lands can be considered a primary prevention activity (health protection) targeted to entire communities. In 1832, with the passage of the Indian Intercourse Act, possession and use of alcohol was prohibited on Indian land. This was repealed in 1953 and since that time, each tribal government has established legal codes regarding the prohibition of liquor. Technical prohibition on reservations is still the norm;

as of 1974, only 92 reservations had laws legalizing alcohol. On reservations where prohibition exists, bootlegging, trips to border towns, and various other forms of contrived access are used to obtain alcohol. Access is more difficult and expensive under prohibition and may lead to more problem-related patterns of drinking than are encountered where alcohol is legal. Dozier (1966) stated that prohibition laws have kept Indians from learning the controlled use of alcohol. The efficacy of prohibition in preventing alcohol abuse is questionable and in need of closer scrutiny; the reasons for maintaining prohibition on 69 percent of the reservations are not well understood.

Legalization of Alcohol Sales and Consumption

Referenced in: May 1975, 1976, 1977; May and Smith 1988; and Back 1981.

Since 1953 each tribal government has had the power to establish legal codes regarding the prohibition or legalization of alcohol sales and consumption. As of the end of 1974, 31.4 percent of the 293 reservations in the lower 48 United States had passed laws containing increasingly more complex elements, ranging from the introduction, sale, and possession of alcohol to the specification of a taxing system, fees for a license system for retail and wholesale sales, hours of sale, conditions of sale, etc. Preliminary studies have shown that legalization tribes generally have lower rates of both mortality and arrest than similar prohibition tribes. The question of whether legalization could be a partial solution or a deterrent to solving the problems associated with alcohol abuse has yet to be thoroughly researched. Tribes then could act on the empirical results of such research and use the alcohol laws to their benefit.

Legalization is only one policy issue; other important categories of policy to consider and discuss widely in Indian communities are how to control and manipulate alcohol availability for the least problematic outcomes, how to minimize and restrict drinking and driving, how to minimize the drinking of females during pregnancy and males in other high-risk situations, and environmental and health-system changes to reduce trauma and death from alcohol-related behaviors.

The Sweat Lodge Ritual

Referenced in: Hall 1983.

The sweat lodge ritual is one culturally prescribed healing practice that has been readily and widely adopted by alcohol and other drug abuse treatment prevention programs that serve a variety of tribes. It has elements of all four levels of prevention in that, beyond offering mental, spiritual, and physical cleansing, the practice promotes the expression of group unity and commitment to positive cultural values. The spiritual leaders serve as models of sobriety and reliance on traditional culture. A powerful intervention, regular participation in the sweat lodge ritual can integrate the recovering individual into the wider community.

The Sun Dance Ritual

Referenced in: Hall 1983.

Participation in the Sun Dance has been seen as a powerful opportunity to pursue personal reform in which abstinence from alcohol is a major goal. Therefore, it can be viewed as primary prevention.

Cheyenne and Arapahoe Lodge Gourd Clan Group

Referenced in: Albaugh 1973.

Tertiary intervention for male alcoholics in residential treatment consisted of group counseling led by a clan member or elder one or two times a week focusing on Indian values. The clients were encouraged to join and/or participate in ceremonies and dances after discharge from the program.

Alaskan Village Spirit Committees

Referenced in: Vesilind 1983.

Spirit committees have recently been reinstituted in Northern Alaska Native villages. Through this promotion activity, the village elders meet regularly to deal with current issues such as alcoholism.

Alcoholics Anonymous

Referenced in: Dozier 1966; and Jilek-Aall 1978.

Alcoholics Anonymous is a tertiary intervention for alcohol abuse/dependence. The utilization of AA by Indian individuals has been changing over the past 20 years. Whereas at the beginning of this period of observation, AA seemed to be used primarily by the highly acculturated Indian, more recently, AA groups have been developed that adopt Indian culture and attract more group members from the Indian and Native communities.

Programs Targeting Pregnancy and Early Child Care

Child Development Course for Pregnant Women

Referenced in: Berlin 1985.

In this community-wide primary intervention activity, pregnant women are offered opportunities to interact with babies and young children and to learn practical information about child development.

Fetal Alcohol Syndrome Pilot Project

Referenced in: May and Hymbaugh 1983, 1989.

This comprehensive program funded by the Indian Health Service from 1980 to 1982 was developed for the Indian population in New Mexico, southern Colorado, southern Utah, and northern Arizona. The project had three activities that were primary, secondary, and tertiary in scope. Treatment efforts were organized around the establishment of community "developmental clinics" to which developmentally disabled children who were suspected of having fetal alcohol syndrome (FAS) or fetal alcohol effect (FAE) were referred. Multidisciplinary teams conducted the assessments to determine diagnosis and create individual treatment plans for the children and their families. Referrals to local or regional treatment agencies were made for needed services. The care of children with existing FAS/FAE or other developmental problems was a major focus, but the clinics provided a unique opportunity to interface with the parents and provide them with counseling regarding future pregnancies. The clinics also were seen as a way to provide specific, onsite training for local clinicians in the diagnosis of fetal alcohol syndrome.

A second phase of the project entailed community training sessions involving tribal councils, schools, and local government units. These sessions targeted all ages and were less detailed than the training offered to the clinicians. Posters, pamphlets, films, a bibliography on FAS/FAE, a resource guide, and a training guide were disseminated throughout the targeted communities.

The third phase was a research component designed to expand knowledge about FAS among Indians. Specific goals were to establish incidence and prevalence figures for the entire population within that region and for individual tribes, to understand the etiological factors involved in the development of FAS, and to use this knowledge to devise prevention strategies.

National Indian Fetal Alcohol Syndrome Prevention Program

Referenced in: May and Hymbaugh 1989.

A comprehensive, macrolevel FAS prevention program for American Indians and Alaska Natives was funded by the Indian Health Service from 1983 to 1985. The program was designed to provide native communities throughout the United States with the knowledge, skills, and strategies to initiate primary, secondary, and tertiary prevention measures on their own. The key to the program was the training of a cadre of trainer/advocates in all local Indian and Alaska Native communities served by the Indian Health Service. These people were then supported and assisted in their efforts through a variety of means, such as the dissemination of state-of-the-art information and the provision of technical assistance. Evaluation of knowledge gained indicated that the local trainers had substantial success in imparting FAS information to a variety of audiences (prenatal groups, school children, and community groups). Further, the evaluation samples indicated that the knowledge was retained by these groups over time (2-4 months) and diffused among peers in local communities.

Early Intervention Program for All New Mothers and Their Infants

Referenced in: Berlin 1985.

This community-wide primary prevention intervention targeted new mothers who met two to three times each week to share their experiences with other new mothers. The women were taught infant stimulation, much of which was consistent with baby handling traditional to many tribes. A third component of the program was that the mothers exchanged babies with other mothers for 1/2 hour each week to further their practice of infant stimulation.

High School Pregnancy Program

Referenced in: Berlin 1985.

This Indian high school-based primary prevention program was offered to pregnant girls and fathers-to-be and consisted of classes on practical child care and effective parenting, parenting vis-a-vis tribal customs and traditions, and problem-solving skills. The belief was that increasing the adequacy of parents would contribute to healthy emotional, social, and intellectual development in the children.

Developmental Task Framework Project

Referenced in: Dinges et al. 1974; Dinges 1982; and Beiser and Manson 1987.

This project developed family-based efforts to promote mental health among rural, isolated Navajos through interactional activities between parents and children. The objectives noted were cultural identification, strengthening family ties, and enhancing child and caregiver self-image.

Child Care Training for At-Risk Adolescent Females

Referenced in: Berlin 1985, 1987.

This early primary intervention program targeted a high-risk group of potential dropouts who drank, had problematic relationships with family, and associated with other depressed individuals. Female high school students were offered paid child care jobs at the local tribal child care center. To continue with the program, they had to complete essential high school courses and participate in child development seminars. Respected community elders participated in the seminars, and the experience stimulated the formation of a peer group centered around child care issues, which also elicited discussion on their own development. The participants usually completed high school and did not continue to drink.

Programs Targeting Youth in Foster Care

Whipper Man Tribal Group Home

Referenced in: Shore 1975; Shore and Nicholls 1975; Shore and Keepers 1982; and Beiser and Manson 1987.

The Whipper Man Project is a model primary intervention incorporating the Native concept of the Whipper Man as disciplinarian in the development of a tribally operated group home for children and adolescents, aged 1-18, who were removed from their family of origin because of neglect or abandonment. The link between alcohol abuse in the parents and the neglect of children was articulated in the development of this facility, which provided short- and long-term placement counseling. Intensive outreach family counseling, outpatient followup, and case management were made available. Some of the accomplishments of this program included a reduction in the length of time that adolescents spent in jail and a reduction in off-reservation referral for foster care.

Alternatives to Foster Care Program

Referenced in: Ishisika 1978; and Beiser and Manson 1987.

This primary prevention intervention, Alternatives to Foster Care Program, provided families with apartment units in a residential facility. Services included child care, child management counseling, employment and social service advocacy, dietary counseling, and case management services. Alcohol and other personal functioning problems were referred to treatment services available in the general community.

Programs Targeting Indian Boarding School and Public School Populations

Preventive Mental Health Program for Indian Boarding School

Referenced in: Shore 1975.

This early example of a school-based promotional effort recognized that enrollment in this high school boarding school was often made on the basis of disorganizing social or interpersonal factors that made most of the student body at risk for dropping out and alcohol abuse. A survey identified the factors that were related to dropouts for the school. The school board was actively involved from the beginning with the consultants in writing a successful grant to provide alcohol abuse counseling and education for the student body. In addition to the counseling staff, a peer counseling program was developed. Another effective intervention proved to be the behavior management training program for the dorm aides, which led to a more nurturing dorm environment.

Toyei Dormitory Model

Referenced in: Goldstein et al. 1974; Shore and Keepers 1982; Beiser and Manson 1987; and Oetting and Dinges 1972.

This is the classic example of a school-based promotional effort, although of short duration owing to funding. It used Navajo houseparents in a significantly higher ratio of adults to children than normal in most boarding school staffing. Special training for these houseparents and instructional aides was provided to better equip them for their individual roles. Compared to children in a control boarding school, students in this boarding school demonstrated better emotional adjustment, accelerated development, and superior performance on tests of physical endurance and strength.

Chemawa Indian Boarding School Recreational Therapy Program

Referenced in: Beiser and Manson 1987.

A promotional recreational therapy program was developed at Chemawa Indian Boarding School. The objectives of the intervention were to reduce student risk for depression, use of alcohol and other drugs, truancy, and antisocial behavior. Outdoor adventures were planned and carried out by self-selected students under the guidance of two recreational therapists. These outdoor activities were designed to promote psychological well-being.

Rough Rock Demonstration School Project Eagle

Referenced in: Beiser and Manson 1987.

Educational reforms have included attempts to balance mainstream American life with curricula designed to maintain and foster cultural identity and parental involvement. These endeavors also attempt to place power in the hands of local school boards and to provide continuing education. These two projects are successful examples of these activities.

St. Mary's Boarding School

Referenced in: Kleinfeld 1982; and Beiser and Manson 1987.

Noticing that upperclassmen and graduates of St. Mary's, a remote boarding school in southwest Alaska, appeared to have an unusually high degree of psychological health ("well put together"), this promotional bicultural program was examined. Students were selected who were oriented toward the values and ideals of the school, thus fostering a peer culture that supported the institution's ideology. One of the unusual features of this educational system was the close relationship between teachers and students. The Catholic faculty of Jesuits and Ursuline Sisters was able to bring tradition and stability to the institution as well as knowledge of the students' way of life. Volunteers, young college graduates working without pay as an expression of their commitment to Christian service, not only taught but spent most of their free time with the students—in the dorms, aiding in the planning of special events, and helping with home work and chores. Education, counseling, and role-modeling took place in these informal contacts with the young volunteers that went beyond normal teacher-student relationships.

Combining traditional Eskimo values with religious and western ideals, St. Mary's stressed responsibility to others—being useful in the world and a help to the community. Traditional arts and crafts were encouraged. Planning skills were developed through the organization of recreational activities.

Mt. Edgecumbe Dormitory Project

Referenced in: Harvey et al. 1977.

This primary prevention intervention used a small dormitory for students with severe behavioral problems. Group interaction and participation in dorm management were promoted. Additional staff training was available for coping with these severe behavioral problems.

Inhalant Abuse Intervention in an Elementary Boarding School

Referenced in: Schottstaedt and Bjork 1977; and Manson et al. 1982.

An attempt to interrupt dependence on inhalants at an early age was instituted at an Oklahoma Indian boarding school. Promotional activities centered on reducing adult-child ratio in the dorms, improving staff morale through child management training, and limiting access to the abusive substance. An example of promotional social action organized by a local youth group is illustrated in the campaign to get stores in nearby towns to stock paint and glue supplies out of reach of youth. A volunteer recreation component was added to improve the children's afterschool experience. Continued consultation to dorm aides was a primary intervention, and the provision of individual alcohol and other drug counseling to targeted habitual users was a tertiary intervention directed at eliminating this problem within the school. The authors discuss the theory that glue sniffing is a precursor of alcoholism and that the identification and treatment of glue-sniffing children becomes an important strategy for preventing alcoholism.

Support Group for Achieving Female Adolescents in a Boarding School

Referenced in: Berlin 1982 and 1985.

Adolescent suicide attempters were identified and an intervention devised. The group consisted of girls in a boarding high school who were bright, attractive, and chosen to be debate captains, cheerleaders, etc. The Indian belief that it is not appropriate to be better than one's peers had resulted in harassment and emotional distress for these achieving girls, and several had attempted suicide. Primary and secondary interventions included featuring tribal leaders as speakers in classes and student forums in which they sanctioned the need to be good learners and leaders of their people. Support groups of parents, counselors, and leaders were effective in relieving these adolescents of this bicultural dilemma.

First-Offender Program for Alcohol- and Drug-Abusing Adolescents and their Parents

Referenced in: Berlin 1985, 1987; and Snyder 1981.

First offenders and their parents were court ordered to participate in 10 family therapy sessions in which a Native counselor assisted each family in solving the problems that they were experiencing.

Grade School Depression Project

Referenced in: Berlin 1985, 1987.

A variety of individual and group counseling sessions were targeted to fourth, fifth, and sixth grade children from dysfunctional alcoholic families who showed signs of depression. Lacking nurturance, these children were enabled to deal better with feelings of abandonment.

Papago Indian Reservation School Group Therapy Program

Referenced in: Kahn et al. 1974.

This primary school-based program consisted of group sessions targeted at potential school dropouts who were referred by the school counselor and the truant officer. These male adolescents were offered payment for their attendance. Formal presentations were made on salient issues such as "family discord" and "Indian culture." Another aspect of the group was the discussion of their problems and their feelings. A marked decrease was observed in the number of arrests and school absences following the implementation of the program.

Project Catch-Up

Referenced in: Mason 1968, 1969; and Manson 1982.

This primary prevention program focused on intensive academic summer instruction. Group vocational counseling was also directed to the socially disadvantaged Indian youths who participated. On followup, although academic performance showed no significant improvement, school dropout rates proved to be lower than the control group.

Adolescent Indian Therapy Group

Referenced in: Hammerschlag 1974.

An elective course entitled "Human Relations" was offered as a secondary prevention to urban and reservation youth attending a boarding high school. Some of the problem areas for these youth were academic delays, bilingual language difficulties, and social problems (behavioral and familial). The course met for 2 hours each week for a period of 6 months. The course instructor was a mental health professional who facilitated the group much as one would a therapy group. The formation and maintenance of interracial relationships was a fundamental theme of the group.

Assertiveness Skills Training for Bicultural Competence

Referenced in: LaFromboise and Rowe 1983.

This primary prevention strategy focused on assertiveness training in a small group setting that used instruction, modeling, behavioral rehearsal, reinforcement, feedback, skill improvement, and generalization to the natural environment. Skills training is applicable to a wide range of problem areas that are particularly relevant to Indian people, such as stress management, problem solving, parenting, alcohol and other drug abuse, and coping with depression. Social acceptance of skills training relies upon the relevance of its goals to American Indian concerns regarding coping in two or more culturally different worlds, self-determination, and effective communication.

Life Skills Training with Adolescents

Referenced in: Gilchrist et al. 1987; Bobo et al. 1988*a*, 1988*b*; and Schinke et al. 1985.

Cognitive-behavioral learning theory was the basis for these primary prevention interventions, which were field tested in tribal and public schools with junior high school youth. The intervention consisted of an educational group format of 10 to 12 sessions, with peer support and monitoring between sessions. Content areas that were addressed included information and stereotypes about Indian culture (spirit dancing, questing, singing, drumming, and use of native custom, language, and healing practices), successful Indian role models, problem-solving skills, coping skills including relaxation skills, interpersonal communication, discrimination skills, and the development of healthy social networks.

Peer-Managed Self-Control Prevention Program

Referenced in: Carpenter et al. 1985.

This primary program targeted to Indian students enrolled in a residential high school predicated its interventions upon the idea that training youth about responsible consumption of alcohol may be a realistic goal. Three approaches were implemented and evaluated. In the first approach, students participated in an alcohol education class that focused on controlled social drinking, alcohol abuse, and alcoholism. In addition, the students contracted with peer counselors to monitor their blood alcohol content (BAC) three times a week, with the goal being to lower the levels.

In the second approach, students met with a peer counselor three times a week, monitored the BAC, and contracted to lower the levels. The third group of students met with a peer counselor, monitored their BAC, but made no contracts.

Evaluation at the 4-, 9-, and 12-month followup revealed no differences among the three groups, and each group decreased their alcohol use and changed their attitudes about use/abuse.

Community-Based Programs for Youth

Mt. Edgecumbe Comprehensive Alcohol Program (MECAP)

Referenced in: Harvey et al. 1977.

Mt. Edgecumbe Comprehensive Alcohol Program (MECAP) was a student-run alcohol education and counseling program. This primary endeavor trained and used peer counselors. The project functioned from 7:00 p.m. to 2:00 a.m. Friday and Saturday nights from a renovated building used as a detoxification center.

Chevak Village Youth Association (CVYA)

Referenced in: Kleinfeld 1982; and Beiser and Manson 1987.

To aid in the development of adaptive values and skills, a youth organization in the Alaskan Catholic community of Chevak was established as a village institution. It was started by local young people for their own recreational activities and developed into an organization that planned and sponsored all the recreation for the community. This primary intervention viewed all young people of the village as members.

Observation of the CVYA activities indicated that it served multiple social, educational, economic, and community service functions. CVYA sponsored league basketball, Eskimo and western dances, and two annual festivals. It raised its own operating funds, and a third of the activities provided a community service. Stressing group process, group but not individual accomplishments were recognized. The education was on traditional skills, alcohol and other drugs, skill building in planning and organization, and role-modeling.

The Acoma-Canoncito-Laguna Teen Center

Referenced in: Beiser and Manson 1987.

This program was one of the successful teen interventions surfacing within the Indian communities. The center's promotional activities included counseling, rap sessions, health education, workshop for teens and parents, acne and weight control programs, and inservice training for staff. Recreational activities were promoted such as exercise classes, library, and the development of a newsletter. This particular center was housed in a local junior/senior high school but remained organizationally distinct. It did, however, cooperate with the school to reduce absenteeisms and vandalism.

DARE

Referenced in: Beiser and Manson 1987.

Launched by the Ute Mountain Ute Tribe, this promotional program that was modeled after the "Dare To Be You" curriculum emphasized decisionmaking abilities, assertiveness, self-respect, and self-esteem. It was intended to assist youths at risk for alcohol and other drug use, truancy, and delinquency.

Residential Programs for Youth

Fort Hall Medical Detoxification Center for Adolescents

Referenced in: Ogden et al. 1970; and Shore et al. 1972.

A medical holding facility was created on the reservation to hold adolescents and young adults picked up by the police for acute intoxication. The youth were detained locally under medical supervision instead of being held in the off-reservation jail. Other secondary prevention activities were the provision of crisis counseling by on-call tribal volunteers and referrals for individual and family therapy.

Youth Chemical Dependency Center at North Dakota State Hospital

Referenced in: Query 1985.

A special facility was developed to offer tertiary intervention to Indian and Anglo drug-abusing young adults from age 14 to 23. The 4- to 6-week residential program found reality therapy to be an effective approach for these youth.

Cultural Enhancement for Youth in the Community

Mescalero Health Fairs
Hopi Health Fairs

Referenced in: Beiser and Manson 1987.

The Mescalero and Hopi offer two good examples of effective learning mechanisms through classroom activities. Their development of learning centers that follow up themes introduced through local mental health fairs illustrates the important role that community-based tribal health fairs can play in promoting well-being as well as calling attention to the problems of Indian youths.

Miccosukee Culture Program

Referenced in: Lefley 1982; and Beiser and Manson 1987.

The two promotional components of this cultural intervention under the control of tribal elders involved 2-day overnight trips of small groups of children to an ancestral Miccosukee campsite in the Florida everglades and formalized instruction in the school setting. Additional time was devoted to traditional Miccosukee arts and crafts. This program saw a reduction in the distance between actual and ideal self-perception, increased preference for Indian stimuli, and an increase in the correlation between personal and ethnic self-perception.

Tiospaye Project

Referenced in: Mohatt and Blue 1982; and Beiser and Manson 1987.

Spiritual advisors and traditional healers were involved in an attempt to reduce various social pathology indicators among Indian children and adolescents (e.g., arrest rates, delinquency, vandalism, alcohol-related accidents). This promotional effort organized a series of community development projects that were designed to rebuild the *tiospaye*, an expression of traditional Lakota lifestyle. This lifestyle is based on the extended family and shared responsibility.

Activities included consultation in regard to community needs and reorganization of the community by-laws. Building of a log meeting house and the introduction of other small subsistence projects met the interest of the residents and were a forum for educational efforts. A quilting cooperative was started as well as a local community television station. All interventions were conducted by local tribal members—staff or residents. The project was able to demonstrate that social pathology rates slowed noticeably in the experimental community as opposed to its controls.

WIDO-AKO-DA-DE-WIN

Referenced in: Red Horse 1982; and Berlin 1987.

This project was designed within a cultural framework to use the natural support network as a promotional and primary prevention model for services to Indian adolescents. (WIDO-AKO-DA-DE-WIN is an Ojibwa word meaning "networking.") The participants were identified as experiencing life difficulties that might be ameliorated by social services. Project staff met weekly with social workers. The major goals were to form a cohesive support group and to integrate project activities into the existing family systems. Cultural activities such as Pow Wows and feasts formed a continuing thread throughout the group process. It also served as an integrating component for primary clinical family and individual counseling.

The success of the pilot program led to the school-based WIDO-AKO-DA-DE-WIN. This innovative approach used the concept of family as treatment. Its primary goal was to develop a family support network for Indian students at South High. Promotional classes were offered in a group setting, and individual and family counseling sessions were offered to all students as a form of primary prevention. Curriculum development covered personal assessment, communication skills, values, norms, Indian traditions, chemical dependency, family systems, male-female relationships, health education, parenting, and school support systems. This focus was intended to clarify Indian values and identity in an urban setting. The use of an Indian elder as teacher in the classroom and trips to various reservations increased sociocultural support networks for the teens. Information was also disseminated on health and personal relationships to help the teens plan or prevent pregnancies. School attendance, performance, and family relations improved and frequency of encounters with the juvenile justice system decreased during the project.

Family Mental Health Program—Urban Housing Project

Referenced in: Red Horse 1982.

This program, located in a densely populated urban housing unit, emerged as a response to a large number of Indian families being fractured through child protective services. All program strategies were adopted with community input and participation. Three traditional elders were hired to service the traditional families within the community. Rituals, ceremonies, and traditional healing practices were used to bring families together and strengthen family relationships. Pow Wows reinforced family structure and provided role models for the youths, and also served as a tool for promoting community organization activities, i.e., fundraising, cultural advocacy, and lobbying. Other promotional activities directed at all levels of families included consultation to medical services, recreation programs, diagnostic evaluation tool revision to reflect traditional health beliefs, services to teens, and preschool services.

Primary clinical operations encompassed routine crisis counseling and case management. The extended family system was identified for child placement when needed. Representatives of each major tribe were hired as staff, and interventions were planned using the appropriate tribal member. A parallel Indian-controlled service system emerged comprising alternative schools, recreational programs, health and social services, legal aid, group homes, an all-purpose Indian center, and half-way houses. A comprehensive network review model consolidated awareness of mental health issues and organized child care concerns.

Project Nak-nu-we-sha

Referenced in: Robbins 1982.

An innovative primary child abuse/neglect demonstration project on the Yakima Indian Reservation provided foster care, medical, counseling, and receiving home services. To end the inappropriate removal of abused children from their kinship system, all area-wide Indian child welfare cases were monitored, completely halting adoption of children off the reservation. This was accomplished through intensive casework and advocacy services. All but 4 of the project's 23 foster homes were placed within the local community. Whenever possible, foster placements were within extended family or close family friends.

The project focused on the family unit and conducted crisis and followup counseling, counseling in problematic areas, and case management. The project coordinated the delivery of multiple community resources and services. An effort was made to increase community awareness of child abuse and neglect and to develop positive alternatives to neglect and assaultive behavior. The counseling program was directed to Indian adolescents suffering from abuse/neglect and alcohol and other drug problems. Indian paraprofessionals were used in the identification and assessment process, capitalizing on their familiarity with the Native language and beliefs.

Given its licensure as a child placement agency, the program was viewed as a resource by the courts and probation officers. Its widespread coordinating function was crucial to program success.

Multidimensional Prevention and Intervention Program on the Manitoulin Island Indian Reserve

Referenced in: Fox et al. 1984; Ward 1984; and Berlin 1987.

Both school-based and community-based activities made up this program, which targeted the entire community. Most of what has been written has described tertiary interventions, specifically the Rainbow Lodge Recovery Centre, a residential treatment facility for alcohol and other drug abuse; the hiring of two mental health workers; and the provision of a traveling mental health clinic.

Promotional interventions within this community included community outreach, community feasts, and spiritual groups. Various recreational and sports programs were planned, stressing the nonuse of alcohol. School programs were offered to enhance self-esteem, traditional values, homemaking skills, and alcohol education. The program also enabled teens to provide community services such as babysitting or cleanup. Training of local tribal members to function as mental health workers was paramount to the program's success.

Primary interventions were comprehensive, beginning with the residential treatment facility. Youth considered to be at highest risk for alcohol and other drugs and suicidal behavior were trained to perform residential facility jobs. These jobs entailed community service, managing exercise equipment, and transportation. Consultation was made available when needed to detention facilities and law enforcement. Backup consultation to the mental health workers was provided by the traveling mental health team. Alcohol and drug abuse education was an integral part of the treatment process. Crisis, individual, family, and group counseling services were conducted by the mental health workers. Local hospitalization was sought in emergency medical and psychiatric situations.

Programs Within Behavioral Health Clinics

Papago Community Mental Health Clinic

Referenced in: Kahn and Delk 1973; and Kahn et al. 1980.

A psychological clinic on the Tohono O'Odham Indian Reservation (formerly the Papago) engaged in a number of promotional interventions: a teen center, training tribal mental health workers, using and consulting with Native medicine persons, and consulting with community groups. Although many primary interventions were targeted to specific risk groups for suicide, alcohol and other drug abuse was also targeted through educational efforts.

Psychiatric Consultation to Tribal Council

Referenced in: Green 1982.

General and child primary psychiatric consultation were provided to a local Indian Health Service clinic and a tribal health and social service branch. These service programs included group homes, a foster home program, an outpatient program, several alcohol and other drug programs, and a traditional resources program.

USET Program—Seminole Tribe

Referenced in: Haven and Imotichey 1979; and Manson 1982.

This primary program operating in the United Southern and Eastern Tribes (USET) was one of 14 tribal mental health programs whose primary function was community prevention with a major emphasis on alcoholism. USET's general approach was comprehensive and designed for its specific services populations. This particular program assisted 2,000 tribal members through the Special Services Department. Programming included mental health, alcoholism, and other drug abuse. Specific activities were not differentiated. Six mental health technicians and counselors covered three clinics and four reservation sites. The Indian medicine program for mental health was important to this agency's success.

USET Program—Miccosukee Tribe Department of Community Mental Health and Alcoholism

Referenced in: Haven and Imotichey 1979; and Manson 1982.

Triage, counseling, and treatment were the main goals of this program servicing Indians in the Miami area. Special primary efforts by two Native medicine specialists, three mental health technicians, and one licensed clinical psychologist were devoted to community stress monitoring.

USET Program—Eastern Band of Cherokee Indians Mental Health and Alcoholism Program

Referenced in: Haven and Imotichey 1979; and Manson 1982.

This comprehensive mental health, alcoholism, child abuse, and drug abuse primary program worked closely with an IHS hospital psychiatrist to serve approximately 6,000 Indians. Five counselors and mental health technicians were assisted by a wide range of consultants from local colleges and mental health centers. When these articles were written, programming was directed toward day care and half-way house concepts.

USET Program—Coushatta and Chitimachi Tribes

Referenced in: Haven and Imotichey 1979; and Manson 1982.

Each of these tribes had an active mental health and alcoholism primary program offering crisis intervention, referral, and aftercare followup. Their promotional effort was educationally oriented.

Community Response to Suicide Epidemic

Referenced in: Tower 1988.

In bringing an adolescent suicide epidemic to a close, a multistrategic approach was used simultaneously with traditional means. Statistics on suicide attempts and completions have been maintained since 1970. A rise in this secondary register prompted immediate crisis counseling and long-term grief counseling with family and friends. Outside psychiatric consultants were used during this crisis for planning the prevention of further attempts. Referrals were increased to a residential treatment facility for alcohol and other drug abuse. Supportive primary school counseling was targeted to this large at risk group. Legal intervention resulted in specific language insertion in an anti-drug abuse act providing funding for additional training.

Traditional ceremonies were reinstituted that reinforced and promoted cultural pride and led to a decline in community anxiety. Spiritual leaders formed an ecumenical religious front to aid the community.

Promotional strategies also included hiring additional mental health, law enforcement, and juvenile staff. The schools developed learning labs; recreational programs including dances, holiday parties, and field trips were instituted. The bingo hall was opened one night a week for the teens' use. Education of the community and organization of a youth recognition award were additional intervention activities.

The communication system was upgraded to include a 24-hour call emergency response that facilitated rapid hospitalization. Tertiary efforts such as long-term counseling and case management were employed to prevent further deterioration.

Following these positive changes, agencies were developing an integrated system of services dealing with mental health, child protection, alcoholism, job training, law and order, school programs, and recreation.

Alternative Community-Based Mental Health Prevention Program

Referenced in: Fleming 1981 and 1983; and Neligh 1988.

A Mental Health Indian Studies Group implemented two primary preventive interventions combining traditional Indian values and group therapy techniques. The participants were chosen from current case loads. The program was able to demonstrate reductions in the frequency and severity of emotional problems among participants. Mental health concerns were addressed by cultural specialists, spiritual advisers, and healers through group discussion during cultural activities. The Family Counseling/Cultural Center located in the community of St. Ignatius provided a place for cultural awareness activity and group education/therapy. The Kootenai Mental Health Indian Studies Program, in Elmo, invited grade school children to participate in the group once a week, thus facilitating intergenerational discussions.

Cultural Therapy Program

Referenced in: French and Hornbuckle 1979.

Staff members (enrolled members of the tribe), Indian clients, and other interested tribal members participated in informally structured Cherokee cultural sessions. The assumption was that reestablishing a strong sense of cultural pride alleviates problems facing the Native American. This promotional model had three basic objectives: (1) to increase the clients' social integration back into the community by enhancing their feelings of belonging; (2) to reinforce the clients' awareness of their proud cultural heritage; and

(3) to offer constructive, positive, and acceptable avenues for tension release.

Ute Tribe Alcoholism Information and Counseling Program on the Uintah and Ouray Reservations
Jicarilla Apache Alcoholism Program
Nevada Inter-Tribal Council Alcoholism Program

Referenced in: Shore and Von Fumetti 1972.

Residential alcohol and other drug abuse treatment was offered on three reservations at the tertiary intervention level. The results underscore the necessity of matching the philosophy and methods to the specific needs of a particular population of alcoholics. One example was reported: Out of respect for the special cultural characteristics of these tribal groups, group meetings were structured to avoid the situation in which a confession of behavior or the sharing of intimate feelings was a primary goal.

Intervention Program Planning

Reservation Improvement Model

Referenced in: May 1987.

This author urged consideration of prevention programming directed not only at the individual but also at community morale. Promotive activities that would enhance the "collective tribal identity" include increased public tribal leadership in human services (education, housing, health, and social services), increased advocacy of self-determination in governmental and legal matters, the development of new recreational facilities and increased visibility of leaders and role models who affirm the importance of tribal customs, community, and family.

Navajo Alcohol Abuse and Education Project

Referenced in: Navajo Health Authority 1979.

The project elements described here were mostly tertiary in nature and reflected comprehensive treatment services for alcohol-abusing individuals. Examples were medical/nonmedical detoxification programs, residential treatment, group homes, outpatient treatment, and day centers. This health planning document listed several recommendations for prevention efforts: community-wide education targeting parents, health providers, and tribal leaders; school-wide education (preschool–high school); troubled employee programs; and interventions targeted to high-risk young people such as the children of alcohol abusers and children yet to be born.

National Association for Native American Children of Alcoholics

Referenced in: Seattle Indian Health Board 1988.

The National Association for Native American Children of Alcoholics (NANACOA) was formed in 1988 with the vision of breaking the multigenerational cycle of addictions in Indian families and communities. The thrust of the association is primary prevention and its specific objectives are (1) to establish a national network and newsletter for Indian children of alcoholics, (2) to develop education and supportive information for dissemination to Indian communities, (3) to hold a national conference for Indian children of alcoholics and those concerned about that target group, and (4) to inform local and national policymakers about the needs of Indian children of alcoholics and influence positive social change toward a healthy community.

Address: NANACOA, P.O. Box 3364, Seattle, WA 98114.

Four Worlds Development Project

Referenced in: Four Worlds Development Project 1983.

The Four Worlds Development Project was funded by the Canadian National Native Alcohol and Drug Abuse Program of Health and Welfare for the purpose of developing effective prevention strategies for Canadian Indian communities. The project received its initial vision and direction at a conference held in Lethbridge, Alberta, in 1982. The participants were Native elders, spiritual leaders, and professionals from diverse Indian communities in North America. The belief articulated by that group was that the problem of Native alcohol and drug abuse cannot be resolved by propagandizing Native people about the ills of alcohol and other drug abuse. Rather, young Native people need a code to live by, ideals, and a vision of the future for Native society that is rooted in the strengths of the traditional past. It is a holistic approach to education and health that draws on the traditional teachings of Native culture as well as contemporary research. The project has developed curricula and training programs for Indian communities.

Address: Four Worlds Development Project, Faculty of Education, The University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, Canada T1K 3M4.

Summary

Of the approximately 80 articles perused, nearly 70 examined prevention activity. Of these, 60 actual intervention programs were considered and reviewed. Fifty-five percent of the programs were providing some activities that could be classified as promotional; 68 percent were primary, 13 percent secondary, and 35 percent tertiary in regard to alcohol and other drug-specific risk factors. A summary of all of the frequencies and percentages for the four types of prevention strategies is found in table 1.

The predominant *promotional* activities were education/training. More than half of the promotional programs had a sociocultural component. Twenty-seven percent provided recreational opportunities and 24 percent provided consultation. Table A-1 (in appendix A) lists the 33 programs that described promotional activities.

Primary interventions targeted at a particular risk group were mainly individual counseling and psychotherapy services (49 percent) and education and/or training (44 percent). Approximately one-quarter of the primary interventions involved the development of culturally relevant experiences and/or provided consultation services. Another large group of programs established a special facility (24 percent) and provided group treatment (22 percent). Table A-2 lists the 41 programs that described primary strategies.

Over half the programs providing *secondary* intervention offered individual counseling and/or psychotherapy. More than a third provided group treatment, and a quarter provided a referral service and/or a special facility for individuals identified in the early stages of alcohol and other drug abuse and dependency. Information about the eight programs that described secondary intervention is detailed in table A-3. It is important to note that the least used prevention strategy was secondary prevention. This might indicate a need for more case-finding approaches that identify children who are in imminent danger and providing them with extensive services that will keep them from developing an entrenched drug-using lifestyle.

Counseling and/or psychotherapy was also made available in almost half of the programs identifying *tertiary* care. Fifty-two percent provided group treatment. A social-cultural component was described in 43 percent, and over a third of the tertiary descriptions provided a special facility as an intervention for those individuals whose alcohol or other drug abuse and dependency were well established. Details about the 21 programs identifying tertiary care are found in table A-4.

Taking into consideration that we do not know the current status of the programs examined and are not evaluating the actual delivery of services, information gathered from this literature review suggests that the most comprehensive alcohol and other drug abuse prevention intervention programs were Inhalant Abuse Intervention in an Elementary Boarding School and the Community Response to Suicide Epidemic. Both of these programs were described as providing promotional, primary, secondary, and tertiary intervention techniques. The most referred to interventions were Native American Indian Church, Life Skills Training with Adolescents, Toyei Dormitory Model, Whipper Man Tribal Group Home, and Handsome Lake Cult and False Face Society of the Iroquois.

Rigorous evaluations were not done on the effectiveness of most of the reviewed programs. The work of Schinke and Gilchrist using the social learning model is the exception, and their work sets a standard for future program evaluation. This type of program needs to be extended to larger populations so that the issue of

Table 1.—Summary of prevention activities from literature

Prevention activities	Promotion N	Promotion (%)	Primary N	Primary (%)	Secondary N	Secondary (%)	Tertiary N	Tertiary (%)
All programs	33	(55)	41	(68)	8	(13)	21	(35)
Individual treatment	1	(3)	20	(49)	5	(63)	10	(48)
Education/training	24	(73)	18	(44)	1	(13)	1	(5)
Cultural activities	19	(58)	12	(29)	1	(13)	9	(43)
Consultation	8	(24)	11	(27)	1	(13)	2	(10)
Special facility	3	(9)	10	(24)	2	(25)	8	(38)
Group treatment	1	(3)	9	(22)	3	(38)	11	(52)
Social action	4	(12)	4	(10)				
Self-help	1	(3)	2	(5)	1	(13)	4	(19)
Legal			2	(5)				
Recreation	9	(27)	1	(2)				
Referral for treatment			1	(2)	2	(25)	1	(5)

generalizability can be addressed. Followup at periodic intervals would also answer the question of the long-term effects of the intervention.

In conclusion, the majority of the alcohol and other drug abuse prevention programming reported in the literature involves primary counseling and/or psychotherapy and promotes community education/training and cultural enhancement. Most of the literature was limited in the scope and detail of prevention activity mentioned, making complete categorization difficult and in some cases incomplete.

Analysis of Grantee Projects

The Office for Substance Abuse Prevention, through its Division of Demonstrations and Evaluation (DDE), has identified key clusters of grants focusing on factors such as age, ethnicity, types of strategies employed, and risk factors. Within the ethnicity cluster, 18 grants in 12 States target American Indian and Alaska Native populations (see figure 1).

This section analyzes several dimensions of these projects. The information was gathered through a variety of activities that included (1) a careful reading of the proposals describing the interventions, (2) the administration of a telephone survey to project representatives, and (3) site visits to four projects. The ultimate goal of the research was to highlight the central issues in developing, implementing, and maintaining services that have high promise for preventing alcohol and other drug abuse among Indian and Native people.

Synopses of Projects

Rural Alaska Community Action Program

Comprehensive Demonstration Project for High-Risk Youth
Anchorage, Alaska

This project has both school-based and community-based elements of prevention programming for six villages (two Aleut, two Eskimo, and two Indian). Among the promotive activities are the identification of a resident alcohol resource person for each village; consultation leading to a needs assessment that involved the entire village; the offering of community workshops that feature information on personal development, community development, and cultural values/ideals; and the development of a holistic preschool through grade 12 curriculum.

A primary intervention was the development of month-long educational workshops that targeted high-risk populations. Case finding (tertiary intervention) was a result of the promotive and primary intervention activities, and referrals were made to agencies on the village, regional, and State levels. Tertiary activities for both community members and school-aged children included the provision of individual and group therapy and the support of self-help groups.

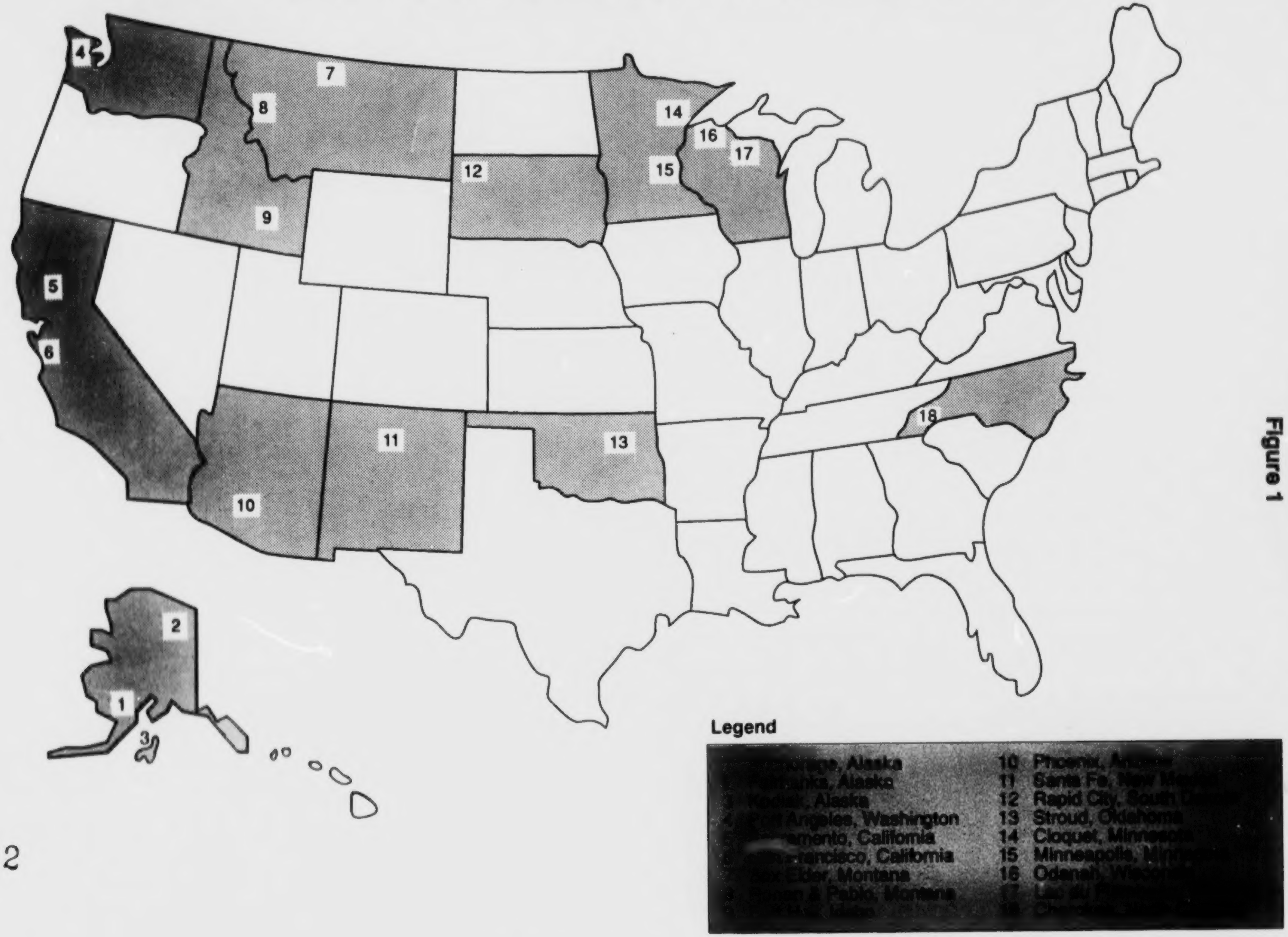
Tanana Chiefs Conference, Inc.

Targeted Prevention for High-Risk Alaskan Village Youth
Fairbanks, Alaska

This project represents the application of a community-based model of intervention in 36 Athabascan villages in Alaska. An underlying goal is to empower the villages to help themselves. The specific target group consists of all youth living in these villages who are between the ages of 5 and 20, and thus, most of the activities can be considered promotive in nature. Village elders and leaders were consulted heavily in the beginning to guide the needs assessment process. They further assisted in the selection of youth organizations (Boy and Girl Scouts, etc.), which were then modified to provide the structure for conveying positive village values and beliefs through recreation and cultural activities. The activities were designed to develop the youths' problemsolving and social competency skills. The elders continued to serve as consultants for the youth of the village primarily through the organizations.

Adults were involved with an economic development program that promoted knowledge about the appropriate use of and respect for natural resources and also allowed the youth an opportunity to develop and practice economic skills. The youth were involved with community service activities to promote their positive identification with the community. An annual village youth conference served to celebrate this identification and was also an opportunity for specific alcohol and other drug abuse education. Promotion of

Location of American Indian and Alaska Native OSAP Demonstration Projects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Legend
1 Anchorage, Alaska
2 Fairbanks, Alaska
3 Kodiak, Alaska
4 Port Angeles, Washington
5 Sacramento, California
6 San Francisco, California
7 Box Elder, Montana
8 Ronan & Pablo, Montana
9 [illegible], Idaho
10 Phoenix, Arizona
11 Santa Fe, New Mexico
12 Rapid City, South Dakota
13 Stroud, Oklahoma
14 Cloquet, Minnesota
15 Minneapolis, Minnesota
16 Odanah, Wisconsin
17 Lac du Flambeau, Wisconsin
18 Cherokee, North Carolina

Figure 1

the beauty and strength of diverse cultures was accomplished through a regional youth conference held four times each year.

Primary prevention was evidenced in the leadership training that was given to the adults involved with the youth organizations and to the youth leaders. Youth group leaders were then better able to identify peers that would benefit from a referral for specialized services such as individual counseling, and this case-finding constituted a secondary prevention activity.

Kodiak Council on Alcoholism, Inc.

Comprehensive Adolescent Alcohol and Drug Abuse Grant
Kodiak, Alaska

This is an enlargement of an existing community-based program that has been sponsored by four agencies. The early detection procedures (secondary prevention) of the local school district identify the candidates (students and their families) for the program interventions.

Youth aged 10-18 who are caught under the influence or in the process of distributing drugs are suspended from public school for a period of time and referred to a day treatment program (Wings) that serves as the nucleus of primary prevention activities. This diversion program is used instead of legal proceedings. Each referred child is assessed in several dimensions: emotional, behavioral, physical, educational, social, spiritual, cultural, and alcohol and other drug involvement. The students receive onsite academic schooling for half of their day-long involvement. Other activities are alcohol and other drug education, parent skills workshops, parent support groups, AA and Narcotics Anonymous (NA) for the youth, family counseling, Alaska Native counseling, recreational activities, and aftercare support groups for the graduates of the program.

A group home is available for youth from out of the area who have been referred for this intervention. In addition to most of the above services, these youth also benefit from the therapeutic milieu of the group home. An advisory board consisting of agency representatives and citizens meets regularly to provide input about the program's development. A video demonstrating the characteristics of this program will be distributed statewide.

North Olympic Alcohol and Drug Abuse Program

Comprehensive Student Assistance Program
Port Angeles, Washington

Four high schools in Clallam County, Washington, serve as the base for this project. The adolescents and their families are the targets for the interventions. The promotion of healthy lifestyles is a motivating force behind the workshops, which are offered to the public at large. Effort is made to contract with nationally and regionally known speakers to draw the attention of the community.

This project delivers primary prevention through several avenues, starting with a series of education and training opportunities. Alcohol and drug awareness classes for students and teachers are offered in the school setting. These classes include life skills and choice training. Alcohol and drug awareness classes are offered to the parents of the students. Groups to support parents were formed using the structure and philosophy of Families Anonymous. A major primary intervention was the training and utilization of Natural Helpers, a cadre of peer counselors. A school team was formed to identify high-risk students for referral for evaluation by professionals and to establish intervention plans for these youth. Consultation between the school and parent groups, child protective service, juvenile justice programs, and community alcohol programs was a key activity that facilitated effective coordination among these entities. With regards to the Makah Indian catchment area, consultation was offered to the west end outreach substance abuse agency that serves Neah Bay.

Early case finding is a secondary prevention that is inherent in the school team and the Natural Helpers team. Tertiary services in the form of individual counseling, group counseling, and family therapy are offered to those identified as in need. All of these program elements are believed to support a school environment that facilitates recovery for the students who abuse substances.

Shoshone-Bannock Tribal School

Early Intervention for Indian Children
Fort Hall, Idaho

The goal of this primarily school-based program is to reach most of the junior and senior high Indian youth enrolled in a nonresidential tribally controlled school with information about alcohol and other drugs and cultural pride. The parents of the students are also targeted with a variety of community-based activities.

Primary prevention activities for the students themselves are numerous, beginning with the inclusion of a formal alcohol and other drug abuse prevention curriculum, *Here's Looking At You, 2000*, into the academic curriculum. Classes on Native American Studies (arts, crafts, history, etc.) are also integrated into the academic curriculum. Bibliographic materials on alcohol and other drug abuse and health are available to the student body through the school library.

Counseling for students and their families is provided in the following ways: school counselors are available for one-to-one and family sessions; youth group sessions led by a counselor provide an avenue for discussing problems; and Alateen is available. Other secondary and tertiary interventions include screening and assessment of high-risk youth for inclusion in a special program within the school that addresses special needs such as behavior problems and referral for alcohol and other drug treatment utilizing community resources.

Primary prevention for parents takes the form of sessions that clarify cultural values and provide for multigenerational exchanges about cultural knowledge, e.g., tribal history, stories, arts, and crafts. A summer family campout is organized to celebrate and solidify cultural identification. Parent groups also identify and model involvement in healthy, drug-free mainstream recreation and leisure.

Social action is addressed in the development of a child advocacy board that includes parents and oversees the treatment program of students with behavior problems. Parents also are involved in developing plans to recruit parents into active participation in the many elements of this project. Ongoing feedback about the progress of the project is given to the school student body and the community at large.

Confederated Salish and Kootenai Tribal Health Department of the Flathead Reservation

Comprehensive Blue Bay Healing Center
(referred to as the Blue Bay Project)
Pablo, Montana

Although all of the Indian residents of the Flathead Reservation are considered to be the target population, this program is designed to involve non-Indians in its many program elements. This is particularly true of the school-aged population who attend the seven schools located on the reservation. Special groups that are targeted are human service providers and leaders at the tribal and community levels. This project advocates that healing and awareness of health need to take place not only at the individual and family levels, but also at the community level.

Promotive activities are the implementation of the *BABES*, *Here's Looking At You, 2000*, and *Four Worlds* curricula in the seven schools for kindergarten through high school grades; the scheduling of chemical-free activities for youth and/or adults (one example is the celebration of sobriety campout that takes place each summer); and the utilization of elders and cultural leaders in the planning and implementation of Indian studies classes and celebratory events.

During the initial months of this project, primary prevention has taken the form of training the project staff and other human service providers in assessing and healing their own areas of personal and familial functioning that have been compromised by community and family alcohol or other drug abuse patterns. This emphasizes the creation of a reservation-wide network of recovering and actualizing individuals who, in the next stage, model the healing and learning process for community members. Support groups for adult children of alcoholics and the establishment of an employee assistance program within the tribal personnel department are examples of this intervention. Three dropin youth centers were developed, and youth support groups were formed, some of which directly reach out to children of alcohol and other drug abusing parents. Culturally prescribed healing practices such as the Talking Circle are incorporated into the structure of the support groups for adults and youth.

Secondary and tertiary interventions include extensive assessment of high-risk youth and their family systems to identify needs from a variety of perspectives, referral of individuals and family units to in-house and contract therapy services that offer both residential and outpatient chemical dependency treatment, and day-treatment services for adults and youth.

Chippewa Cree Tribal Business Committee

Rocky Boy CAT Team's PRIDE Project
Box Elder, Montana

This school- and community-based project has at its core two teams (the CAT Team and the Awareness Team) whose goals are to establish and oversee the implementation of an assessment and training plan for the Rocky Boys Reservation communities. Members of the teams are trained to assess alcohol and other drug use in individual youth. A unified plan was developed to reduce student transfers among the three schools on or near the reservation. The teams also oversee a student survey of alcohol and other drug knowledge and a parent survey that asks about attitudes toward alcohol and other drug abuse intervention. A centerpiece of much of the promotional and preventive activities is the establishment of a special facility, an afterschool resource learning center, for youth and their families.

Promotive activities include the *Here's Looking At You, 2000* curriculum in the school system; minicourses for youth; four training sessions for the teams, students, school faculty, elders, parents, and community members; chemical-free alternative activities (an example is karate) for youth and community members; and cultural activities in the afterschool program. Coordination of the alcohol and other drug treatment resources that are available in the community is an important part of the Pride Project. The project itself offers career counseling to students, and a chemical dependency counselor is available to provide tertiary treatment for individuals and groups.

Arizona Department of Education

Standing Strong: Targeted Prevention for Indian Youth
Phoenix, Arizona

The recipients of this school-based intervention are Indian children aged 3-10, their parents, and their teachers in three sites representing three groups: (1) children and their families from rural reservation areas who are newly arrived in the urban setting, (2) children and their families living in a reservation setting that is near an urban center, and (3) children and their families who are living in a rural reservation area. The primary prevention focus for this project was the development of an early childhood education curricula for alcohol and other drug abuse prevention. These curricula contain culturally relevant material and specifically address communication issues with children, parents, and teachers who interface with two or more cultures.

Primary prevention in the form of workshops for children, parents, and teachers is a major activity. The goals of the workshops are to impart knowledge about intervention/prevention strategies and effective relationships between parents and teachers. Workshops that are solely directed to parents also include information about career development that would benefit these adults in making family decisions in that arena. Training seminars and technical assistance are also provided to community representatives who could serve as catalysts for intervention/prevention activities in their own communities.

Santa Fe Group Homes, Inc.

The Neuva Vida: Comprehensive Prevention, Treatment, and Rehabilitation Demonstration Project
Sante Fe, New Mexico

This school- and community-based project is an extension of an existing program that serves the triracial (Anglo, Hispanic, and American Indian) population of Santa Fe and its surrounding rural area. This project specifically targets children, grades K through 6, and their families. Another target group consists of adolescent females who demonstrate involvement with alcohol and other drugs. Consumer involvement is actively sought, and a network of providers, advocacy groups, and community consumers is maintained as part of this project's goals. An outcome of this promotional activity is a survey of existing community resources. The presence of bilingual staff also signals the desire to serve the unique needs of the ethnic minority communities.

Within this catchment area, primary intervention takes the form of educational groups for high-risk elementary school children and their parents. Individual and group therapy is provided to students and their parents as needed. New secondary and tertiary services are provided through the establishment of a satellite clinic in an underserved rural community. The staff of this clinic complete indepth assessments of chemical-abusing adolescent females for possible admission to the residential treatment facility. Individual and group therapy is provided to these girls and their families. Narcotics Anonymous, Alcoholics Anonymous, and Children of Alcoholics groups are also part of the treatment regime. Upon discharge, aftercare counseling is coordinated with community agencies.

Sac and Fox Tribe of Indians of Oklahoma

Calling All Kids Project
Stroud, Oklahoma

Indian and non-Indian youth aged 3-21 and their families who reside in the catchment area of the Sac and Fox Tribe are the recipients of this comprehensive school- and community-based program. The interventions range from promotive to tertiary levels. The program stresses the philosophy that all races need to be responsible for finding solutions to youth alcohol and other drug use. A planning board has been established that is composed of representatives from diverse parts of the community. This is the mechanism for maintaining long-term planning. Parent action groups and special interest groups also allow for community ownership and input.

Community leaders are prepared to deliver training on alcohol and other drugs, communication, and parenting skills. The youth receive both alcohol and other drug information and life skills training. Peer counselors are also trained and serve as resources for the school-aged population. Individual counseling focusing on future goals and career planning is offered. Youth group interventions include a support group for pregnant teens, a self-esteem group for fourth and sixth graders, Alateen, Alatot, Teens Helping Teens, and career development groups. A parent support group is also an essential part of the primary prevention program.

Widespread screening efforts that address the dimensions of chemical dependency and physical, emotional, and mental health identify the youth most in need of primary and tertiary intervention. Referral and transportation services are offered to youth in need of residential treatment. Outpatient individual and family aftercare counseling is offered. A youth retreat is part of the aftercare package for those who have had residential chemical dependency treatment.

Indian Health Board of Minneapolis, Inc.

Soaring Eagles: Targeted to American Indian Youth
Minneapolis, Minnesota

A social center for youth and families is the site for the delivery of this set of community-based prevention services for children aged 3-20 and their families. The availability of these services to all Indian families in the urban Minneapolis area makes this effort promotive in nature. Twice a month the children meet with the program staff for an evening of events that serve several purposes: to recognize each child's academic achievements, to provide positive adult role models, and to promote positive social skills in the children. Specific classes address decisionmaking skills and knowledge about Indian culture.

Drug free alternatives for socialization are offered through onsite recreational activities and field trips. An annual family retreat allows the entire extended family the opportunity to participate in these activities as well. The youth engage in community service projects that demonstrate the value of being a contributing citizen of the wider community. At the beginning of each youth's participation in the groups, an individual assessment is completed that addresses these dimensions: alcohol and other drug use/abuse, family issues, academic needs and strengths, self-esteem, and depression. Youth who have been identified as having specialized needs are then referred for psychotherapy or other appropriate services.

Fond du Lac Reservation

Indian Youth Group Home
Cloquet, Minnesota

A special facility was acquired and established as a therapeutic group home for 12 Indian youth, aged 8-18, in need of out-of-home placement. Academic schooling is provided in the home, and the families of these youth are targeted for intervention. The goal is to return the youth after a period of up to 6 months to their families of origin and their home schools with an enhanced ability to function appropriately. Early in the admissions process, the youth are given a chemical dependency evaluation.

Primary prevention takes several forms: alcohol and other drug and life skills education (Project Charlie curriculum and staff-generated classes), an available library of alcohol and other drug and mental health materials (audiovisual and written), a variety of recreational activities; support groups (AA, ALA-TEEN, and COA), and counseling (individual, group, family, and postgraduation followup).

Referrals are made for therapy as needed, and access to tertiary intervention is offered. Opportunities to learn about Indian culture are found in the following circumstances: the in-house school curriculum, a foster grandparent program, regular visits by spiritual leaders and tribal elders, visits by positive Indian role models, and the participation of youth in local tribal ceremonies and cultural events. Another feature of this program is the work-study program, which provides the opportunity for the youth to work within a supportive environment and contribute to the community.

Lac Du Flambeau Band of Ojibwa

Prevention of AODA Problems in Targeted Indian Families
Lac Du Flambeau, Wisconsin

The target population of this project are 21 families who were randomly selected from the total population of parents who were 40 years old or less and who had children in the 6- to 12-year-old range. This community-based primary prevention project, housed within the Elders Resource Center, emphasizes the power of revitalization of cultural values and practices for healthy community, family, and individual development. The elders are viewed as a valuable resource to the targeted families and to the community at large but are also targeted for primary intervention in the form of a support group for themselves.

The teaching of the tribal language by the elders is central in this project and is achieved through intergenerational learning. The parents who participate attend a 14-week Parent Education Program that promotes Indian childrearing practices and beliefs. They also take part in 14-week Ojibwa language training sessions with the goal that they in turn would teach their children. The children separately and with their families participate in culturally oriented activities with the elders on a regular basis. A promotive activity is found in an annual 5-day event that celebrates the cultural knowledge, skills, and intergenerational relationships that have been nurtured through involvement in this program.

Bad River Band of Lake Superior Ojibwa

Ojibwa T.R.A.I.L.S.
Odanah, Wisconsin

This year-long community-based project is an expansion of an existing program that also emphasizes the power of cultural revitalization through promotive and primary prevention activities largely targeted at 250 Indian youth aged 1-18 years and their families. Promotive intervention is accomplished through the delivery of workshops on Indian culture and the administration of an alcohol and other drug awareness survey to all students (Indian and non-Indian) attending the K-12 schools near the reservation.

An advisory board consisting of tribal educators and elders was formed to give guidance on the development of a formal curriculum with five subject areas. They also identify community resources other than themselves for the teaching and modeling of cultural values, knowledge and skills. Specific activities are periodic campouts with the youth, attendance at local and regional pow wows, a mothers' support group, 1-day weekend workshops for youth and their families, recreational activities, and a yearly family appreciation pow wow.

In addition to the consultation received from the elders and community leaders, the program staff are also given special consultation so that their teaching and group facilitation skills are enhanced. The staff also consults with school personnel regarding specific children and families, and consult with families through informal home visits.

Rapid City Girls Club of America

Friendly PeerSuasion: Targeted Substance Abuse Education
Rapid City, South Dakota

This urban program serves Indian and non-Indian girls who have joined the local Girls Club and participate in its recreational and personal development activities. From the membership, several girls demonstrating promise as leaders are enrolled in an 18-hour peer leadership training course that combines the *YAAA!* and *Winner's Circle* curricula. The parents of the peer leaders receive orientation sessions and thus benefit by the information taught to their daughters. Younger girls within the Club are then taught the leadership concepts by the peer leaders.

Cherokee Center for Family Services

Cherokee Challenge Early Intervention Project
Cherokee, North Carolina

This existing community-based recreation program widened its scope to serve youth aged 10-18 who are self-ascribed early alcohol or other drug abusers. It is the court diversion program for those identified through consultation with schools and human service agencies. Primary prevention activities are educational components (ROPES Course and sessions on peer relationships); recreational opportunities that emphasize adventure, education, and service; and the formation of Cherokee youth clans, which become the structure for experientially learning Cherokee culture.

Classification by Prevention Strategies

The vast majority of the prevention interventions are primary in nature (table 2). Social action, education/training, and cultural enhancement were the predominate *promotional* activities, followed closely by recreational components. Table B-1 (in appendix B) lists the 10 projects that described promotional activities.

Primary interventions are mainly education/training and cultural activities. Sixty percent provide consultation to schools, mental health agencies, health clinics, and so forth. Over half of the projects specified the following activities: assessment and/or referral, self-help groups, and social action. Table B-2 lists the 15 projects that described primary strategies.

Assessment and referral services, individual and group therapy and self-help groups are offered in most of the *secondary* projects. Information about the eight projects that described secondary intervention is detailed in table B-3. As a whole, the OSAP-funded projects appear to be identifying youth who are most at risk and are providing them with services that will keep them from developing an entrenched alcohol and other drug using lifestyle. The investment of human and fiscal resources in these types of programs should be very great.

Tertiary interventions are predominately group and individual treatment. The details about the eight projects identifying tertiary care are found in table B-4.

No project established a register to identify individuals at risk such as is done for suicidal behavior. Actions that target legal issues were mentioned by only 2 of the 16 projects. Economic development activities were seldom described.

Table 2.—Classification of OSAP grantee projects by prevention strategies

Prevention activities	Promotion N	Promotion (%)	Primary N	Primary (%)	Secondary N	Secondary (%)	Tertiary N	Tertiary (%)
All programs	10	(30)	13	(94)	8	(50)	8	(50)
Education using established curriculum	7	(70)	14	(94)			2	(25)
Cultural activities	7	(70)	10	(67)	3	(38)	2	(25)
Consultation	2	(20)	9	(60)	2	(25)	2	(25)
Social action	7	(70)	8	(54)				
Referral for treatment	3	(30)	8	(54)	7	(88)	4	(50)
Self-help			8	(54)	6	(75)	5	(63)
Recreation	6	(60)	7	(47)	2	(25)	1	(13)
Individual treatment			6	(40)	7	(88)	7	(88)
Group treatment			5	(34)	7	(88)	8	(100)
Special facility	1	(10)	3	(20)	1	(13)	2	(25)
Economic development	1	(10)	2	(14)				
Legal			2	(14)				
Register								

Finally, 5 of the 16 projects can be described as comprehensive, that is, they provide promotional, primary, secondary, and tertiary intervention techniques. Most of the remaining projects concentrate their efforts in activities at the primary and promotional levels of intervention. Most of these programs use multiple approaches and do not rely simply on education about factual drug information, an approach that has been found in recent studies to *increase* use. Not surprisingly, cultural activities figure prominently in these projects. More investigation is needed to better understand how culture affects the use or nonuse of alcohol and other drugs in Indian youth.

Classification by Site of Intervention

Table 3 categorizes the projects according to the type of activity and site of intervention (school-based, community-based, or based in both school *and* community). Of the 16 projects, 2 can be classified as school-based, 8 as community-based, and 6 as both school- and community-base.

Both of the *school-based* projects described education/training and consultation as their primary activities. All of the *community-based projects* utilized education/training and recreation interventions. The next most frequently described components were cultural activities and social action.

All of the projects that intervened at *school and community* sites have assessment/referral, individual treatment, group treatment, social action, and education/training. The next most frequently described were self-help groups and cultural activities.

In conclusion, these proposals described a wide array of prevention activities, with the most frequently endorsed activities being education/training, cultural enhancement, assessment/referral, social action, and recreation.

Table 3. – Classification of OSAP grantee projects by site of intervention

Prevention activities	School-based N	School-based (%)	Community N	Community (%)	School and community N	School and community (%)	All programs N	All programs (%)
All programs	2	(13)	8	(50)	6	(38)	16	(100)
Education using established curriculum	2	(13)	8	(50)	6	(38)	16	(100)
Cultural activities	1	(6)	7	(44)	5	(31)	13	(81)
Recreation			8	(50)	4	(25)	12	(75)
Social action			6	(38)	6	(38)	12	(75)
Assessment and/or referral	1	(6)	5	(31)	6	(38)	12	(75)
Consultation	2	(13)	5	(31)	4	(25)	11	(69)
Self-help	1	(6)	4	(25)	5	(31)	10	(63)
Group treatment	1	(6)	2	(13)	6	(38)	9	(56)
Individual treatment	1	(6)	1	(6)	6	(38)	8	(50)
Special facility			2	(13)	3	(19)	5	(31)
Economic development			2	(13)	1	(6)	3	(19)
Legal			2	(13)			2	(13)
Register							0	

Telephone Survey

A survey was developed for use in telephone interviews with the program managers of the OSAP American Indian and Alaska Native grants. The goals of the survey were to identify common concerns and observations about family and community life and to identify beliefs that are perceived by the communities themselves to contribute to successful prevention and intervention across these very diverse communities. (The complete survey is contained in appendix C.)

The survey addressed five major dimensions:

- *Philosophy and beliefs*. The items in this section addressed the philosophy and belief systems that guided the development and implementation of each project. It asked for the views on how substance abuse develops in Indian and Native communities, how individuals and communities are protected from the development of substance abuse*, and what is the best way for Indian and Native communities to promote health.
- *Descriptions of project characteristics*. This section focused on the characteristics of the providers of the prevention services and the target population. Other items were designed to elicit descriptions of the context in which the services were offered.
- *Descriptions of specific project strategies*. This section sought to better understand what the specific project activities were and how they were developed.
- *Organizational structure and management*. Four stages were identified in this section: planning, outreach and recruitment, implementation, and evaluation. Questions sought to identify agencies that were available in the community and participated in the work of each of the four stages. In addition, a number of items asked for information about the administrative characteristics of the project, such as the leadership structure and decision-making processes.
- *Project evaluation*. The final section asked the grantees to assess their projects' effectiveness at that point in time. They were further asked to identify the barriers that have arisen during the projects' lifetime and to identify how the project might improve so that positive impact in the communities could be realized. Lastly, they were asked to describe how they measured client and project outcomes.

The survey was mailed to the 18 OSAP grantees and 16 chose to participate in the telephone interview. A telephone interview was selected as the preferred method of data collection because it allowed for dialog between project representative and researcher. This contributed to an increased understanding of each project's philosophy and the selected interventions. The findings in the five dimensions are summarized below.

Philosophy and Beliefs

Factors That Place an Indian Person at Risk for Substance Abuse/Dependency

Poor self-esteem and parental alcoholism were both indicated by those questioned to be the most significant risks for substance abuse (table 4). Substance abuse by peers and friends followed closely, with abuse/neglect and family conflict/disruption next. Sexual abuse as a child and emotional/psychological difficulties were indicated by over one-half. Previous suicide threat or attempt, poor and inconsistent family manage-

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* "Substance abuse" is used throughout this section because the survey questions used that terminology.

Table 4.—Factors that place an Indian at risk for alcohol and other drug abuse/dependency

	Significance			
Risk factor	None	Some	Moderate (in percents)	Great
Parental alcoholism	–	–	13	88
Poor self-esteem	–	–	13	88
Substance use by friends and peers	–	–	17	81
Abuse/neglect	–	6	25	69
Family disruption or conflict	–	13	17	69
Emotional/psychological difficulties	–	6	44	56
Sexual abuse as child	6	17	17	56
Person's early substance use	–	6	38	50
Poor and inconsistent family management	6	13	31	50
Alienation from social values of Native American culture	6	25	17	50
Previous suicide threat or attempt	17	13	17	50
Poor or undefined racial identity	–	6	50	44
Poor relationships with family members	–	13	44	44
High absenteeism	–	25	31	44
School dropout	6	25	25	44
Personal physical assault	17	13	25	44
High unemployment in community	–	17	44	38
Multiple home placements	6	17	38	38
Sensation seeking	13	13	38	38
Community disorganization	6	31	25	38
Inadequate healthy recreational activity	–	17	50	31
Risk taking	6	13	50	31
Criminal behavior in parents or siblings	6	25	38	31
Delinquency/crime	–	38	31	31
Recent death of relative or friend	6	31	31	31
Poor academic performance	6	38	25	31
Inability to metabolize alcohol efficiently	17	31	17	31
Alienation from social values of white culture	13	38	25	25
Frequent moves	17	31	25	25
Parental divorce	13	44	17	25
Low socioeconomic background	17	38	17	25
Low commitment to education	13	50	13	25
Attention deficit disorder and hyperactivity	25	25	31	17
Negative boarding school experience	17	38	25	17
Cognitive deficits	25	44	13	17
Lack of attachment to neighborhood	38	17	31	13
Depressed autonomic and central nervous system arousal	17	56	13	13
Physical handicap/illness	31	50	17	–
Other:				
Rapid cultural change	–	–	–	6
Community-wide unresolved grief	–	–	–	6
Lack of family education	–	–	6	–
Perception of alcohol as normal	–	–	6	–

ment practices, person's early substance abuse, and alienation from social values of the white culture were factors highlighted by 50 percent.

It was interesting to note that more than one-third of the respondents placed little importance on lack of attachment to community as a significant risk factor for substance abuse/dependency, even though all the projects stressed community-based program intervention activities. Nearly one-third did not think physical handicap/illness was influential, and one-fourth indicated that cognitive deficits and attention deficit disorder were likewise not notable risk factors.

Protective Factors

Looking at personal protective factors, persons having a defined spiritual belief system and/or positive self-esteem were thought to be most shielded from substance abuse/dependency (88 percent). Being able to make decisions based on internal beliefs about personal responsibilities (69 percent) and/or to act independently (63 percent) were also highlighted. Persons holding strong positive values for academic achievement and/or having the ability to know when it is appropriate to depend on others were noted by half the respondents.

All of the protective environmental factors listed were judged to be greatly significant by half or more of the respondents. This suggests that the majority responding to the questionnaire felt that of all the protective factors listed, healthy environmental factors have a more protective quality than personal factors. Parental protective factors were seen as the most important elements in preventing substance abuse/dependency. Nearly all respondents (94 percent) believed that parents who model appropriate and healthy behavior are the best defense against substance abuse. Three-fourths indicated that persons perceiving respect from parents are significantly safeguarded. Parents who demonstrate positive interpersonal skills and/or have a value system that is clearly and consistently communicated were felt by 63 percent of the respondents to be shielding offspring from substance abuse. Over half listed setting limits for child's behavior by the parent as being important.

Positive societal factors such as friends/peers modeling appropriate and healthy behavior were thought by three-fourths to be greatly significant in the prevention process. If society's expectations for healthy and appropriate behavior are clearly communicated, 63 percent felt the person was least likely to become dependent on substances. Fifty percent felt the demonstration of positive interpersonal skills by friends and peers (peer modeling) to be helpful.

Philosophical Influences

Of those listed, the most substantial influence on program development and philosophy (69 percent of respondents) was that espoused by the Children of Alcoholics literature. Tribal beliefs were a close second. One-fourth of the programs ascribed to the philosophy of the 12-Step traditions. Eighty-two percent were moderately influenced by the Alkalai Lake experience. Of those listed, the Four Worlds Development Project and The Red Road were the least used approaches in the development of the projects' philosophies with 67 and 63 percent, respectively, responding to "never heard of" and "little or no influence."

Intervention Goals

The general intervention goals stressed most often were recognizing risk factors, increasing/enhancing program or community resources, promoting cultural identity, and promoting mental health (94, 88, 88, and 81 percent, respectively). Influencing legislative actions was indicated by only 17 percent of those responding.

Project Characteristics

Project Responsibility

Fifty percent of the programs were developed and implemented by the tribe. The remainder were operated by a private/nonprofit corporation.

Additional Funding

Additional State funds were received by 44 percent of the programs, while 31 percent supplemented their funds with Indian Health Service monies, and 31 percent, with contributions or donations.

Setting of Prevention Activities

The majority of the programs were community-based (see table 5), with all programs having some community prevention activity. Forty-four percent were directed from a substance abuse outpatient clinic, and more than one-third provided services in the elementary, junior, and senior high schools.

Duration

Seventy-five percent of the programs conducted an indeterminate number of sessions/classes, while one-half of the respondents held a predetermined number of sessions/classes.

Schedule

The majority of the programs (88 percent) implemented programming during the daytime on weekends. Eighty-one percent of the projects planned activities for daytime during the week and/or weekday evenings. One-half promoted weekend evening programs.

Table 5.—Setting of prevention activities

Setting	Percent of projects
Community	63
Home	31
School	
Preschool	31
Elementary	44
Junior High	44
Senior High	38
Community College	13
Four-Year College	13
Human Service Agency	
Child Welfare Agency	25
Court/Legal Agency	25
Other	13
Outpatient Clinic	
Medical Health Clinic/Program	31
Substance Abuse Clinic/Program	44
Mental Health Clinic/Program	25
Hospital	17

Languages Used

Eighty-one percent of the projects used the English language 90-100 percent of the time in program activities, with 44 percent using English exclusively. Over one-third used Indian/Native language 2-10 percent of the time.

Target Population

All of the projects included both sexes in their target populations. Ninety-four percent directed their activities to adolescents (13-19 years old), 69 percent to school-aged children (6-12 years old), and 50 percent to preschool children (4-5 years old) (figure 2).

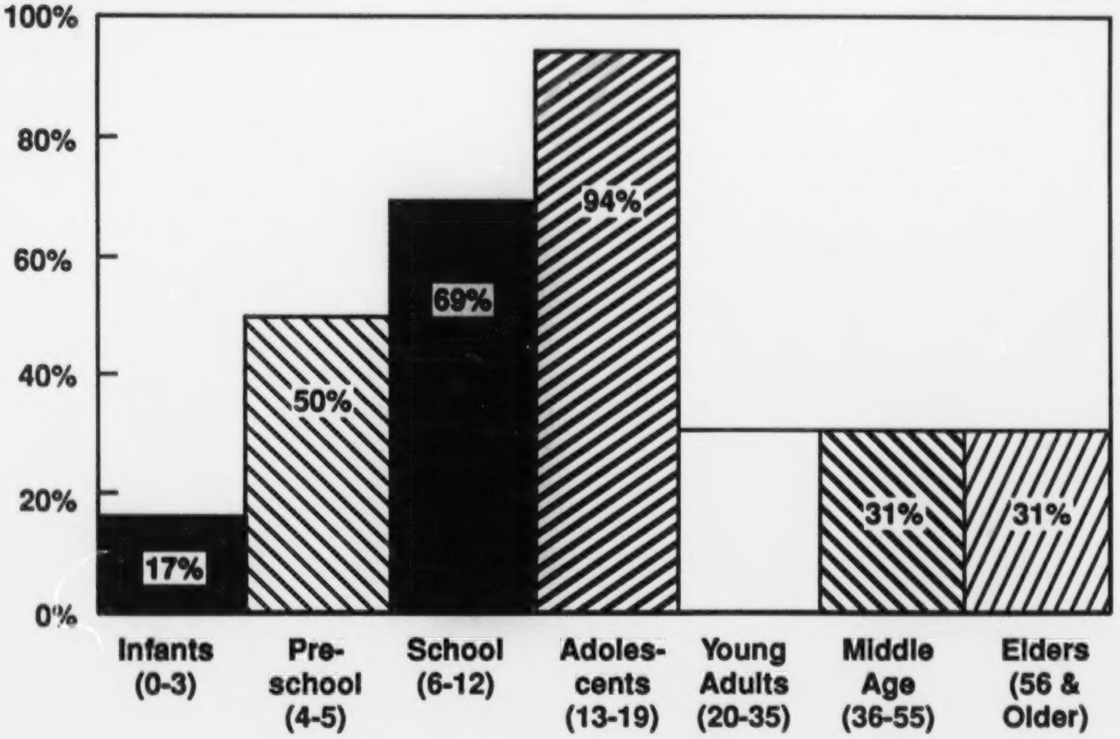
Ethnicity of Target Population

American Indian and/or Alaska Natives comprised three-quarters of the client population 90-100 percent of the time, with 38 percent exclusively targeting Indians/Natives. Caucasians were 0-10 percent of the participants in 63 percent of the programs, while other minorities were 0-10 percent of the target group in 88 percent of the projects.

The respondents listed 25 tribes in their client population:

Aleut	13 percent of programs
Apache	6
Athabascan	13
Blackfeet	6
Chippewa/Cree	6
Chippewa	17
Clallam	6
Cocopaw	6
Eastern Band of Cherokee	6
Eskimo	6
Haida	6
Hopi	6
Inupiat	6
Makah	6
Navajo	13

Figure 2
OSAP Target Population



Pima	6
Pomo	6
Salish-Kootenai	6
Shoshone-Bannock	6
Sioux	13
Tlingit	6
Tohono O'odham	6
Tsimpshian	6
Yupic	13

Residential Status

Eighty-seven percent of the programs targeted reservation communities, while two of the programs dealt with urban populations. Two programs targeted reservation youth exclusively. Forty-four percent of the projects accounted for 80-100 percent of their clients' residential status.

Indian/Native persons who live primarily in an urban setting were targeted exclusively by only one program, and 25 percent programmed no activities for urban settings. For 36 percent of the programs, 2-10 percent of their Indian population lived in the city. Thirty-eight percent of the programs did not target Indians that selectively migrate between Indian reservation/community and urban settings; 94 percent included 1-20 percent of these Indians in their client population.

Referral Mechanism

Ninety-four percent of the respondents used another agency for referrals (the school was included in this category). Sixty-nine percent served self-referrals, while 63 percent of the programs had referrals through family channels; 56 percent had in-house referrals and 38 percent received court referrals.

Number of Participants

The current number of participants ranged from 0-100 in 44 percent of the projects and

100-300 in 17 percent. Two programs targeted 301-450 participants. Twenty-five percent did not respond to this question. Total number of participants since the beginning of the project fell between 0-100 for 31 percent of the programs, while 25 percent had 100-300 and 25 percent had 301-500 participants; 17 percent did not respond.

Provider Education

Eighty-one percent of the paid providers had completed a bachelors degree; 75 percent had attended some college or received an AA; 69 percent had a masters degree and 25 percent had a doctorate. A high school education was the highest level of formal education for 56 percent of the paid providers. Thirteen percent had completed specialized training pertinent to their activities.

Provider Ethnicity

Fifteen of the sixteen programs responding employed American Indians/Alaska Natives. Of the total employees, 70 percent were American Indian/Alaska Native, 10 percent other minority, and 20 percent Caucasian.

Specific Project Strategies

Family Involvement

All the projects responded that they had some involvement with families. Fifty percent indicated great involvement and 31 percent, moderate involvement.

Community Involvement

All the projects involved the community in some aspect. Seventy-five percent claimed great community involvement in their planned activities.

Cultural Involvement

All but one of the programs based their program to some degree on aspects of Indian/Native culture. Sixty-nine percent programmed cultural activities a great to very great extent.

School-Based Interventions

Education in which an established curriculum was not used was the major school-based activity for the prevention of substance use/abuse (see table 6). Fifty percent of the programs provided referrals for counseling. Education using an established curriculum, self-help groups, and group counseling were important activities. Thus, promotional education and secondary traditional counseling and/or referral services were the main school-based project interventions. Legal interventions were not planned in any of the projects interviewed.

Community-Based Interventions

Promotional efforts seemed to be the main thrust of the community-based interventions, with education not using an established curriculum as the most frequently noted activity (table 6). Other interventions commonly used included recreational promotional interventions, cultural activities and education using an established curriculum, traditional psychotherapy techniques, referral for counseling, individual counseling, case/program consultation, and group counseling.

Types of Curriculum

One-quarter of the projects using established curriculum utilized *Here's Looking at You, 2000*. *BABES*, *Children are People*, *Positive Indian Parenting*, and *Sacred Tree* were each used by 13 percent of the respondents. The majority of the respondents used their own project-developed curricula.

Organizational Structure and Management

Planning Stage

The average length of the planning stage was 12 months. Over one-third scheduled 6-10 months for preparation work. As expected, representatives from the substance abuse program were involved in this stage of program development in 100 percent of the projects. Representatives from social service programs and the adult population at large were involved 75 percent of the time, while representatives from mental health programs, schools, and the adolescent population participated in more than two-thirds of the programs. Individuals from the elder pop-

Table 6. – Intervention approaches

Available activities	Percent of projects
School-based interventions	
Education/training not using established curriculum	69
Referral for counseling/psychotherapy	50
Group counseling/psychotherapy	44
Self-help groups	44
Education/training using established curriculum	44
Individual counseling/psychotherapy	38
Cultural activities	31
Case/program consultation	31
Recreational activities	25
Special facility	25
No school-based intervention	17
Social action groups	13
Special register	6
Legal intervention	—
Other	
Assessment	13
Community-based interventions	
Education/training not using established curriculum	81
Referral for counseling/psychotherapy	63
Individual counseling/psychotherapy	63
Recreational activities	63
Case/program consultation	63
Group counseling/psychotherapy	56
Education/training using established curriculum	56
Cultural activities	56
Self-help groups	38
Special facility	31
Legal intervention	17
Social action groups	13
Special register	13
No community-based intervention	—
Other:	
Community service for elders	6
Education/training for service provider	6

ulation were involved in 63 percent of the programs.

Outreach/Recruitment Stage

Approximately 91/2 months were spent in identifying and attracting potential project participants from the target group; 38 percent required 6-15 months. Representatives from the adult and adolescent population were involved in outreach and recruitment in 81 percent of the projects. Of the programs surveyed, three-quarters of the respondents cited assistance from the school system, whereas 63 percent indicated they received assistance from mental health and/or social service programs. Over one-half involved parent groups, representatives from the elder population, and/or substance abuse programs in their outreach and recruitment efforts.

Project Implementation Stage

On the average, the programs surveyed had completed 1 year of project implementation, falling anywhere between 0 and 38 months—42 percent indicated 6 to 15 months. The majority of the projects were funded for a number of years and were still in the implementation phase. Eighty-one percent of the programs had representation from the adolescent population at large. Adult and elder populations and/or substance abuse personnel were involved in 75 percent of the programs, and representatives from social service were involved with project implementation in 63 percent of the projects.

Evaluation Stage

The average time spent in evaluation planning and implementation was 9.6 months. Forty-two percent of the programs spent 1-10 months in program evaluation. Substance abuse representatives were utilized in 63 percent of the responding projects, while mental health, schools, adult, and/or adolescent populations were involved in 44 percent.

Administrative Characteristics

All the programs felt that their administrative characteristics were described by clearly stated goals and objectives, and achievement of these goals being a source of individual initiative and gratification. Half thought these were moderately descriptive and half thought they were perfectly descriptive.

Organizational and Performance Characteristics

Within the area of confidence and trust in staff, 50 percent of the respondents felt they had complete confidence and trust in all matters relating to their staff. All the projects usually (38 percent) to always (63 percent) got ideas and opinions from staff, and usually to always tried to make constructive use of them.

Rewards, occasional punishment, and some involvement in decisionmaking were strategies used by 56 percent of the projects to motivate their staff. Thirty-one percent used economic rewards based on a compensation system developed through participation and/or group participation and involvement in setting goals, improving methods, appraising progress toward goals, and so forth.

The majority of the projects' administrators (69 percent) felt that personnel at all levels felt real responsibility for the organization's goals and behaved in ways to implement them. Eighty-eight percent of the respondents felt good about their organizational communication—that it was flowing down, up, and with peers. Downward communication was generally accepted and, if not, was openly and candidly questioned in 69 percent of the programs. Sixty-nine percent of the supervisors observed that upward communication from staff was accurate. The supervisor knew and understood problems of staff very well in 63 percent of the cases. A very substantial amount of cooperative teamwork throughout the organization was present in 88 percent of the cases.

Fifty percent used a traditional decisionmaking process of broad policy and general decisions being made at the top, with more specific decisions being made at the lower levels. Less than one-third felt that decisionmaking was widely done throughout the organization and well integrated through a linking process. Decisionmakers were generally quite well aware of problems, particularly at the lower levels of the project organization, in 63 percent of the projects. One-quarter felt that they were moderately aware. Staff were involved fully in all decisions related to their work in 63 percent of the cases.

Except in emergency situations, 56 percent of the respondents observed that goals were usually established through group participation. Thirty-one percent responded that their goals were set or orders issued after discussion with staff about problems and planned action. Half of the group felt that their goals were overtly accepted but at times met with some covert resistance, while the remaining half noted that the goals were fully accepted both overtly and covertly.

Forty-four percent felt that there was widespread responsibility for review and control, with lower units at times imposing more rigorous reviews and tighter controls than top management. A moderate downward delegation of review and control, with the lower and higher levels feeling responsible, was noted in 38 percent. Forty-four percent sensed that an informal organization may be present and may either support or partially resist goals of the formal organization. Where informal and formal organizations were one and the same (50 percent), the feeling of support from all social forces in achieving the organization's goals pervaded.

Project Evaluation

Project Effectiveness

When asked on a scale of 1 to 7, ranging from not effective to extremely effective, the majority of the projects (63 percent) rated themselves a 5, with 94 percent falling between 5 and 7.

Barriers to Project Success

Two factors were seen consistently as barriers to the project's success—more time was needed to educate key community leaders, and employing qualified American Indian/Alaska Native providers was difficult. Seventy-five percent or more reported no problem with the following potential barriers: laws that hinder prevention or treatment; input from staff is not encouraged; little or no support or positive feedback from management; philosophy of project is unclear; and poor training. Interesting to note is that 55 percent felt that insufficient funds was a minor or nonexistent factor in the project's success.

Ways to Improve Project

The actions thought to be greatly to all important for improving the project were the implementation of better working relationship with client's family (61 percent); the provision of sufficient time to explain program's philosophy to the community (56 percent); and the implementation of special programs to support open communication across all levels of project operations (56 percent). One action was viewed by 88 percent of respondents as being unimportant in improving the project—influencing legislators to allow drinking on the reservations.

Project Evaluation Designs

Fifty-six percent of the programs had designed both process and outcome evaluations. One-quarter planned only process analysis. Both qualitative and quantitative measures were part of the evaluation plan in 81 percent of the projects. Evaluations by individuals from both within and outside of the host agency were planned by 75 percent of the projects.

Client Outcome Measures

Most projects did not have specific plans about *how* to measure outcome behaviors and knowledge areas but had definite ideas about *what* they wanted to measure. Seventeen percent did not respond to this question. Improved self-image, positive peer interaction, and positive family interaction were each indicated by 69 percent as changes in behavior they would like to see in their measurement of project participants (see table 7). Sixty-three percent listed the acquisition of skills to become a peer leader and 61 percent, reduced alcohol use/abuse. Participants' increased interest in pursuing higher education and acquiring job skills was indicated by only 13 percent of the respondents as a desired outcome variable. This was notable because one of the factors identified as a barrier to the success of the

Table 7.—Outcome measures

Measure	Percent of projects using in-project evaluation
Client Behavior	
Positive peer interaction	69
Positive family interaction	69
Improved self-perceptions	69
Acquired skills to be a peer leader	63
Reduced alcohol abuse	56
Academic progress	56
Reduced alcohol use	50
Developed ways of spending time in a positive manner	50
Reduction of depression, anxiety, fear, and feelings of inadequacy	44
Overall health improvements	44
Gain in sense of personal control	44
Fewer instances of acting out in school	44
Acquired skills to develop mutual-help and self-help groups	44
Ability to form long or short term goals	38
Interest in completing high school	31
Less negative perceptions of school environment	25
Improved eating habits	25
Pays more attention to self-appearance	17
Improved weight gain or weight loss	17
Client feeling of ownership from community	17
Interest in pursuing higher education	13
Acquired job skills	13
Other	
Reduced drug abuse	6
Increased cultural participation	6
Client Knowledge	
Awareness of community resources	75
Physical and emotional effects of alcohol/other drugs	69
Peer pressure and decision making	69
Effective communication	69
Risks to children of alcoholics	69
Values and attitude clarification	63
Self-awareness and culture identity issues	56
Family bonding and enrichment	56
History of alcohol and other drug problems among Native Americans	50
Fetal Alcohol Syndrome prevention	50
Effective parenting	50
Single parenting activities	25

projects was difficulty in hiring qualified Indians/Natives.

Changes in the following areas of knowledge were viewed as important outcome measures: awareness of community resources (75 percent); risks to children of alcoholics (69 percent); effective communication (69 percent); peer pressure and decisionmaking (69 percent); physical and emotional effects of alcohol/other substances (69 percent); values and attitude clarification (63 percent); self-awareness and cultural identity issues (56 percent); family bonding and enrichment (56 percent); history of substance abuse among American Indians/Alaska Natives (50 percent); fetal alcohol syndrome prevention (50 percent); and effective parenting (50 percent).

Project Outcome Measures

Again, it is important to note that most projects did not have specific plans about *how* to measure project and community changes but had definite ideas about *what* they wanted to measure. The number of clients that satisfactorily completed the project was the major outcome variable indicated by 75 percent of the supervisors (see table 8). Other indicators of desired change were reduced alcohol/substance abuse, creation of a followup project, creation of health promotion/disease prevention activities, number of clients that unsatisfactorily completed project, increased participation in outreach projects, and provision of workshops/training for community. The projects desired to reduce the rates of the following alcohol/substance abuse-related problems: teenage pregnancy (38 percent), family violence (31 percent), child abuse/neglect (31 percent), and suicide (31 percent).

Site Visit Reports

The programs that were selected for a site visit represented a cross-section of situations that can be found where Indians and Natives live. Their catchment areas included rural and semirural reservation areas, reservation border towns, and urban settings. Together, they represented interventions targeted at all ages and illustrated the implementation of a variety of strategies.

The site visitors followed the key informant strategy for obtaining information about the projects selected. Wherever possible, the reviewer interviewed the project director, a front-line nonadministrative provider, a community leader, an adult consumer, and/or a youth consumer. The topics discussed generally followed the outline of topics contained in the telephone survey: (1) the philosophy upon which the project is based, (2) the goals of the project, (3) successful outcomes, (4) barriers to success, and (5) recommendations for future programming.

It was generally agreed that a large host of risk factors are present in the lives of most Indian youth, thereby rendering that age group particularly susceptible to alcohol and other drug use. Early intervention was seen as critical, but treatment and aftercare are also needed for those young people who have already adopted a drug-using lifestyle. Even a small but visible group of youth recovering from alcohol and other drug use can be extremely influential in closely knit communities.

The consensus among most of the respondents across sites was that alcohol abuse is a serious community problem and that because Indian youth learn to abuse alcohol from family and/or community members, all facets of the community and the home environment need aggressive intervention. The respondents also underscored that the belief system to which the youths adhere (Indian, non-Indian, or bicultural) should be incorporated into their treatment and prevention situations. Finally, the responses to the interviews revealed a firm belief in the development of a long-term relationship between the prevention team and the Indian community. At every point, from planning through evaluation, the prevention team needs to be highly aware of the impacts of the prevention activities on every part of the community system, even those that are perceived to be underfunctional or nonfunctional.

Summary and Synthesis

A synthesis of the literature review and the multidimensional analysis of the American Indian and Alaska Native OSAP demonstration

Table 8.—Project outcome measures

Measures	Percent used in project evaluation
Number of clients that satisfactorily complete project	75
Reduced alcohol/substance abuse	69
Good followup project instituted	63
Creation of health promotion/disease prevention activities	63
Number of clients that unsatisfactorily complete project	56
Increased participation in outreach projects	56
Conducted workshops/training for community	50
Project developed good relationship with client's family	44
Increased school attendance	44
Good working relationship with staff and client	38
Reduced truancy	38
Decreased disciplinary problems	31
Client not back in the juvenile system	25
Increased number of high school graduates	25
Reduced Fetal Alcohol Syndrome/Effects	13
Quick recovery time for client	6
Reduced alcohol/substance abuse-related problems	
Teenage pregnancy	38
Family violence	31
Child abuse/neglect	31
Suicide	31
Accidents	25
Arrests	17
Trauma	17
Acute episodes of hospital/clinic admission	13
Homicide	13
Cirrhosis	6
Other	
Number of volunteers involved	6

projects reveals that the OSAP projects are consistent with the current state of the art in alcohol and other drug use prevention among American youth in general. Although this is an encouraging conclusion, it is important to keep in mind that the general "state of the art" is still very much in the testing phase. Many programs nationwide are proceeding on untested assumptions and are not using rigorous evaluations that measure the outcomes of their interventions.

The deliberations of a recently convened Task Force on Prevention, Promotion, and Intervention Alternatives in Psychology (American Psychological Association) are reported in a book entitled *14 Ounces of Prevention: A Casebook for Practitioners* (Price et al. 1988). After identifying and describing 14 model prevention programs, the following list of common denominators of success was developed. With the exception of the role of rigorous evaluation, the OSAP-funded

Indian/Native demonstration projects show moderate to strong adherence to these factors.

1. The successful program is targeted. The focus is shaped by a reasonable understanding of the risks and problems encountered by the target group.
2. The successful program is designed to alter the life trajectory of the people who participate in it. It is aimed at long-term change, setting individuals on a new developmental course, opening opportunities, changing life circumstances, or providing support.
3. The successful program gives people new skills to cope more effectively and provides social support in the face of life transitions.
4. The successful program strengthens the natural support from family, community, or school settings.
5. The successful program has managed to collect rigorous research evidence to document its success.

The research literature on adolescent alcohol and other drug use and abuse displays strong agreement about the influence of peers in the decision to use or not to use substances. The research by Oetting and Beauvais has shown that this applies equally well to Indian youth. (Actually, the family seems to play a slightly larger role for Indian youth than for non-Indian youth, although the influence of peers is very powerful.) In light of this, it is surprising that the peer dynamic receives little attention in most prevention programs. This appears to be the case in the Indian/Native OSAP projects. The most one usually sees in these programs is the mention of developing a cadre of peer counselors. Whereas peer counseling represents one important strategy in positively affecting the peer culture, other strategies may prove more effective and deserve close attention as well.

The best prevention programs are those with the broadest application; that is, they do not have to be tailored to each individual community, nor do they depend on a charismatic leader for success. The Indian and Native OSAP projects apply a wide range of curricula and approaches that are being used in a variety of communities across the country. If these approaches can be shown to be effective for Indian youth, our understanding of the general dynamics of alcohol and other drug use will be greatly enhanced. The cultural content of these proven curricula and approaches may have to be changed from location to location, but the base will reflect what works for all youth.

Despite the fact that we are still in the process of identifying the essential elements of effective alcohol and other drug use prevention with American youth, there are indications of progress toward this goal. Drug use rates among Indian and Native youth, as among other youth, are continuing to drop; the rates are still unacceptably high, but they are declining.

At this time, we do not have a clear understanding of this phenomenon, and many explanations are put forth to account for this reduction. It is often attributed to the success of formal prevention programs, such as are represented by most of the Indian and Native OSAP demonstration projects. However, other viable explanations deserve discussion. It may well be, for instance, that the drop in rates is strictly a function of changing attitudes toward drugs, including alcohol, and a willingness on the part of the adult community to forcefully communicate antidrug values. Large antidrug demonstrations have been held recently in many Indian and Native communities. In the summer of 1989, the eight reservations in Montana and Wyoming concluded their seventh annual campout celebrating sobriety within families and communities. Eighteen tribes recently held a drug free festival on the Hualapi reservation in Arizona. A number of tribal councils have recognized the need for sobriety among their ranks before major changes can be expected at the community level. Powerful messages are being sent to Indian and Native youth by these types of activities. It could be that direct programming for youth alone is not as effective as programming directed at community awareness and attitude change; or it could be that a combination of the person-centered strategy and the system-directed approach is optimal.

Recommendations

The findings of this study are encouraging. Clearly, prevention programs in American Indian and Alaska Native communities have employed a variety of strategies based on sound theory and research. Nevertheless, unanswered questions in several key areas suggest several topics for further study.

- Not enough is known about the conditions that lead to the long-term survival of prevention programs in Indian/Native communities. What are the political, social, funding, and other structural elements that support or hinder programs?

- The relationship of traditional culture to drug use is another area for study. Many programs seem to be based on the assumption that anything cultural is good, but what are the specific elements within cultural activities that have either a positive or negative impact on drug use?

- Mechanisms need to be considered to ensure that every project does a rigorous evaluation. There is a particular need for longitudinal impact studies.

- Much remains to be learned about the relationship of peer interactions and the use or nonuse of drugs, including alcohol. Can "peer clusters" be effectively targeted in prevention programs? Are there cultural concepts that can be used to enhance the positive influence of peers among Indian youth?

- The question of whether a prevention program can be effective in the absence of a more general community development effort needs to be explored. Even if short-term gains can be demonstrated with a particular prevention component, can those gains be sustained without an aware and supportive community environment? What are the critical parts of the community that need to be involved?

- Many programs are moving toward more comprehensive approaches. Nevertheless, the role of economic and broader environmental risk factors is rarely addressed. Projects that look more into political and economic risk and protective factors and environmental solutions should be encouraged.

- Progress has been made in changing community norms regarding the use of chemical substances. More focus should be given to how this is accomplished and how to sustain it.

These issues and others can be addressed in the near future if an effective partnership is developed among community members, practitioners, and researchers. There can be no doubt that many Indian and Native communities are weary of the expenditure of human and fiscal resources on chronic care of alcohol and other drug problems and are open to this kind of partnership.

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American Indian and Alaska Native Demonstration Projects

Division of Demonstrations and Evaluation, OSAP

"Comprehensive Demonstration Project High Risk Youth"
RURAL ALASKA COMMUNITY ACTION PROGRAM
731 E. 8th Ave., Box 200908
Anchorage, Alaska 99520
(907) 279-2511
Contact Person: Doug Modig

"Targeted Prevention for High Risk Alaskan Village Youth"
TANANA CHIEF'S CONFERENCE, INC.
1302 21st Avenue
Fairbanks, Alaska 99701
(907) 452-2446
Contact Person: Michael Graf

"Comprehensive Adolescent Alcohol and Drug Abuse Grant"
KODIAK COUNCIL ON ALCOHOLISM, INC.
P.O. Box 497
Kodiak, Alaska 99615
(907) 486-3535
Contact Person: William G. Herman

"Comprehensive Student Assistance Program"
NORTH OLYMPIC ALCOHOL AND DRUG ABUSE PROGRAM
315 East 8th
Port Angeles, Washington 98362
(206) 452-2381
Contact Person: Gayle L. Swagerty

"Comprehensive Community Development and Support Project
for High Risk Youth"
CALIFORNIA DEPT. OF ALCOHOL & DRUG PROGRAMS
20 North Dewitt, Suite 8
Clovis, California 93612
(209) 299-4834
Contact Person: Michael Isaac-Son

"Native American Health Center Prevention Project"
SAN FRANSISCO COMMUNITY CLINIC CONSORTIUM
1520 Stockton Street
San Fransisco, California 94133
(415) 391-9686 Ext. 273
Contact Person: Carroll Johnson

"Rocky Boy CAT Team's PRIDE Project"
CHIPPEWA CREE TRIBAL BUSINESS COMMITTEE
Box 620, R B Route
Box Elder, Montana 59521
(406) 395-4291
Contact Person: Sybil Sangrey

"A Comprehensive Proposal for the Blue Bay Healing Center"
CONFEDERATED SALISH AND KOOTENEI TRIBAL HEALTH DEPARTMENT
P.O. Box 278
Pablo, Montana 59855
(406) 676-2770
Contact Person: Anna Whiting-Sorrell

"Early Intervention for Indian Children"
SHOSHONE-BANNOCK TRIBAL SCHOOL
P.O. Box 306
Fort Hall, Idaho 83203
(208) 785-2080
Contact Person: Gary Brownly

"Standing Strong: Targeted Prevention for Indian Youth"
ARIZONA DEPT. OF EDUCATION
1535 W. Jefferson
Phoenix, Arizona 85007
(602) 255-4391
Contact Person: Kathryn Stevens Begaye

"Comprehensive Prevention, Treatment, and Rehabilitation
Demonstration Project: The Nueva Vida"
SANTA FE GROUP HOMES, INC.
P.O. Box 5739
Santa Fe, New Mexico 87502
(505) 983-9521
Contact Person: Carl Boaz

"Friendly PeerSuasion: Targeted Substance Abuse Education"
RAPID CITY GIRLS CLUB OF AMERICA
C/0 GCA National Resource Center
441 W. Michigan Street
Indianapolis, Indiana 46202
(317) 634-7546
Contact Person: Dolores Wisdom

"Calling All Kids Project"
SAC AND FOX TRIBE OF INDIANS OF OKLAHOMA
Route 2, Box 246
Stroud, Oklahoma 74079
(918) 968-3526
Contact Person: JoAnna Coser

"Indian Youth Group Home"
FOND DU LAC RESERVATION
Human Services Center
927 Trettel Lane
Cloquet, Minnesota 55720
(218) 879-1227
Contact Person: Phil Norrgard

"Soaring Eagles: Targeted to American Indian Youth"
INDIAN HEALTH BOARD OF MINNEAPOLIS, INC.
1315 East 24th Street
Minneapolis, Minnesota 55404
(612) 721-3765 Contact Person: Ellie Webster
(612) 721-7425 Contact Person: Norine Smith

"Ojibwa T.R.A.I.L.S."
BAD RIVER BAND OF LAKE SUPERIOR
P.O. Box 39
Odanah, Wisconsin 54861
(715) 682-5852
Contact Person: Mary Bigboy

"Prevention of ADOA Problems in Targeted Indian Families"
LAC DU FLAMBEAU BAND
Family Resources Center, Box 398
Lac Du Flambeau, Wisconsin 54538
(715) 588-3371
Contact Person: Sonny Smart

"Cherokee Challenge Early Intervention Project"
CHEROKEE CENTER FOR FAMILY SERVICES
Acquoni Road, P.O. Box 507
Cherokee, North Carolina 28719
(704) 497-9101 Ext. 37
Contact Person: Gilliam Jackson

Appendix A

Summary of Prevention Activities from the Literature

Table A-1

Promotional Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Handsome Lake Cult and False Face Society of the Iroquois										X		
Native American Indian Church										X		
Ghost Dance Movement										X		
The Sweat Lodge Ritual				X						X		
The Sun Dance Ritual										X		
Alaskan Village Spirit Committees					X					X		
Child Development Course for Pregnant Women							X					
Early Intervention Program for All New Mothers and Their Infants			X				X					
Developmental Task Framework Project							X					
Preventive Mental Health Program for Indian Boarding School					X		X					X
Toyei Dormitory Model							X			X	X	

Table A-1 (continued)

Promotional Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Chemawa Indian Boarding School Recreational Therapy Program									X			
Rough Rock Demonstration School Project Eagle							X					
St. Mary's Boarding School		X					X					
Mt. Edgecumbe Dormitory Project							X					
Inhalant Abuse Intervention in an Elementary Boarding School					X		X					X
Support Group for Achieving Female Adolescents in a Boarding School										X		X
Chevak Village Youth Association							X		X	X		
The Acoma-Canoncito-Laguna Teen Center							X		X		X	
DARE							X					
Mescalero Health Fairs Hopi Health Fairs							X				X	
Miccosukee Culture Program							X		X	X		

Table A-1 (continued)

Promotional Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Tiospaye Project							X		X	X		X
WIDO-AKO-DA-DE-WIN							X			X		
Family Mental Health Program – Urban Housing Project							X		X	X		X
Project Nak-nu-we-sha							X					
Multi-dimensional Prevention and Intervention Program on the Manitoulin Island Indian Reserve							X		X	X		X
Papago Community Mental Health Clinic							X			X		X
USET Program – Coushatta & Chitimachi Tribes							X					
Community Response to Suicide Epidemic							X		X	X		
Alternative Community-Based Mental Health Prevention Program							X			X		
Cultural Therapy Program										X		
Four Worlds Development Project					X		X			X		X

Table A-2

Primary Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Native American Indian Church				X						X		
Indian Shaker Church										X		
Prohibition								X				
The Sweat Lodge				X						X		
The Sun Dance Ritual										X		
Alaskan Village Spirit Committees					X					X		
Early Intervention Program for All New Mothers and Their Infants			X				X					
High School Pregnancy Program							X					
Child Care Training for At Risk Adolescent Females							X					
Whipper Man Tribal Group Home		X	X								X	X
Alternatives to Foster Care Program		X					X			X	X	

Table A-2 (continued)

Primary Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Preventive Mental Health Program for Indian Boarding School						X						X
Mt. Edgecumbe Dormitory Project		X					X				X	
Inhalant Abuse Intervention in an Elementary Boarding School		X										X
Support Group for Achieving Female Adolescents in a Boarding School			X									
First Offender Program for Alcohol- and Drug-Abusing Adolescents and Their Parents			X									
Grade School Depression Project		X	X									
Papago Indian Reservation School Group Therapy Program			X									
Project Catch-Up			X				X		X			
Adolescent Indian Therapy Group			X									
Assertiveness Skills Training for Bicultural Competence							X					

Table A-2 (continued)

Primary Intervention	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Program												
Life Skills Training with Adolescents							X					
Peer-Managed Self-Control Prevention Program		X					X					
Mt. Edgecumbe Comprehensive Alcohol Program (MECAP)		X					X				X	
The Acoma-Canoncito-Laguna Teen Center		X										
Fort Hall Medical Detoxification Center for Adolescents		X									X	
WIDO-AKO-DA-DE-WIN		X										
Family Mental Health Program-Urban Housing Project		X					X			X	X	
Project Nak-nu-we-sha		X					X				X	X
Multi-demensional Prevention and Intervention Program on the Manitoulin Island Indian Reserve		X					X				X	X
Papago Community Mental Health Clinic		X					X					X

Table A-2 (continued)

Primary Intervention	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Program												
Psychiatric Consultation to Tribal Council												X
USET Program — Seminole Tribe		X								X		
USET Program — Miccosukee Tribe — Department of Community Mental Health & Alcoholism		X										
USET Program – Eastern Band of Cherokee Indians Mental Health and Alcoholism Program		X										
USET Program – Coushatta & Chitimachi Tribes		X						X			X	X
Community Response to Suicide Epidemic		X									X	X
Alternative Community-Based Mental Health Prevention Program		X	X				X			X	X	
Fetal Alcohol Syndrome Pilot Project	X				X		X			X		X
National Indian Fetal Alcohol Syndrome Project					X		X			X		X
National Association for Native American Children of Alcoholics				X	X		X			X		X

Table A-3

Secondary Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Native American Indian Church				X			X					
Inhalant Abuse Intervention in an Elementary Boarding School	X	X										
Support Group for Achieving Female Adolescents in a Boarding School			X							X		
First Offender Program for Alcohol- and Drug-Abusing Adolescents and Their Parents			X									
Fort Hall Medical Detoxification Center for Adolescents		X									X	X
Multi-dimensional Prevention and Intervention Program on the Manitoulin Island Indian Reserve		X					X					
Community Response to Suicide Epidemic		X				X					X	
Fetal Alcohol Syndrome Pilot Project	X	X	X									

Table A-4

Tertiary Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Handsome Lake Cult and False Face Society of the Iroquois		X	X							X		
Native American Indian Church				X						X		
The Sweat Lodge Ritual				X						X		
Cheyenne and Arapahoe Lodge Gourd Clan Group			X							X		
Alcoholics Anonymous				X						X		
Child Care Training for At Risk Adolescent Females				X						X		
Whipper Man Tribal Group Home			X							X	X	
Preventive Mental Health Program for Indian Boarding School		X										
Inhalant Abuse Intervention in an Elementary Boarding School		X										
Papago Indian Reservation School Group Therapy Program			X									

Table A-4 (continued)

Tertiary Intervention Program	Referral for Therapy	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation
Adolescent Indian Therapy Group			X									
Fort Hall Medical Detoxification Center for Adolescents		X										X
Youth Chemical Dependency Center at North Dakota State Hospital		X	X								X	
Mescalero Health Fairs – Hopi Health Fairs		X	X								X	
Papago Community Mental Health Clinic		X								X		
Community Response to Suicide Epidemic		X									X	
Alternative Community-Based Mental Health Prevention Program		X									X	
Ute Tribe Alcoholism Information and Counseling Program on the Uintah and Ouray Reservations			X								X	
Jicarilla Apache Alcoholism Program			X								X	
Nevada Inter-Tribal Council Alcoholism Program			X								X	
Fetal Alcohol Syndrome Pilot Project	X	X	X			X	X			X		X

Appendix B

Summary of Prevention Activities from Proposals

Table B-1

Promotional Intervention Program	Assessment and/or Referral	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation	Economic Development
Rural Alaska Community Action Program					X		X			X		X	
Tanana Chief's Conference, Inc.					X		X		X	X		X	X
North Olympic Alcohol and Drug Abuse Program							X						
Confederated Salish/Kootenai Tribal Health Department of the Flathead Reservation (Blue Bay Project)					X		X		X	X			
Chippewa Cree Tribal Business Committee	X				X		X		X	X	X		
Santa Fe Group Homes, Inc.					X								
Sac and Fox Tribe of Indians of Oklahoma					X				X				
Indian Health Board of Minneapolis, Inc.	X				X		X		X	X			
Lac Du Flambeau Band										X			
Bad River Band of Lake Superior	X						X		X	X			

Table B-2

Primary Intervention Program	Assessment and/or Referral	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation	Economic Development
Rural Alaska Community Action Program					X		X			X		X	
Kodiak Council on Alcoholism, Inc.	X		X	X	X		X	X	X	X	X	X	
North Olympic Alcohol and Drug Abuse Program	X	X		X			X					X	
Shoshone-Bannock Tribal School		X	X	X	X		X		X	X			
Confederated Salish/Kootenai Tribal Health Department of the Flathead Reservation (Blue Bay Project)	X	X		X			X			X	X		
Chippewa Cree Tribal Business Committee	X	X	X		X		X					X	
Arizona Department of Education							X			X		X	
Santa Fe Group Homes, Inc.							X			X		X	
Sac and Fox Tribe of Indians of Oklahoma	X	X	X	X	X		X						X
Indian Health Board of Minneapolis, Inc.	X												
Fond Du Lac Reservation	X	X	X	X	X		X		X	X	X		X
Lac Du Flambeau Band				X	X		X		X	X		X	
Bad River Band of Lake Superior	X			X	X		X		X	X		X	
Rapid City Girls Club of America							X		X				
Cherokee Center for Family Services							X	X	X	X		X	

Table B-3

Secondary Intervention Program	Assessment and/or Referral	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation	Economic Development
Rural Alaska Community Action Program	X												
Tanana Chief's Conference, Inc.	X												
Kodiak Council on Alcoholism, Inc.	X		X	X					X	X			
North Olympic Alcohol and Drug Abuse Program	X	X	X										
Shoshone-Bannock Tribal School	X	X	X	X									
Confederated Salish/Kootenai Tribal Health Department of the Flathead Reservation (Blue Bay Project)	X	X	X	X						X		X	
Chippewa Cree Tribal Business Committee		X											
Sac and Fox Tribe of Indians of Oklahoma	X	X	X	X									

Table B-4

Tertiary Intervention **Program**	Assessment and/or Referral	Individual Therapy	Group Therapy	Self Help	Social Action	Register	Education	Legal Action	Recreation	Cultural Activities	Special Facility	Consultation	Economic Development
Rural Alaska Community Action Program		X	X	X									
Kodiak Council on Alcoholism, Inc.			X	X					X	X			
North Olympic Alcohol and Drug Abuse Program	X	X	X										
Confederated Salish/Kootenai Tribal Health Department of the Flathead Reservation (Blue Bay Project)	X	X	X	X			X			X	X	X	
Chippewa Cree Tribal Business Committee		X	X										
Santa Fe Group Homes, Inc.	X	X	X	X							X	X	
Sac and Fox Tribe of Indians of Oklahoma		X	X				X						
Fond Du Lac Reservation	X	X	X	X									

Appendix C

Telephone Survey

____ ____ ____
1 2 3
(sequence)

OSAP Demonstration Project Survey

TO ALL OSAP GRANTEES:

This survey will allow us to better understand the state-of-the-art prevention activities that are currently being undertaken in American Indian and Alaska Native communities. These communities are very diverse in nature and availability of resources; and yet, all share the common vision of reducing the devastating impact of substance abuse on Indian and Native people. The ultimate goal of this research is to identify those factors which contribute to successful prevention and disseminate this information for others to use.

This survey addresses five major dimensions:

I. Philosophy and Beliefs;

II. Descriptions of Project Characteristics;

III. Descriptions of Specific Project Strategies;

IV. Organizational Structure and Management; and

V. Project Evaluation.

Your experience, insights and observations are extremely valuable to this effort. Please feel free to answer exactly as you feel.

Thank you for your participation in this exciting research!

I. PHILOSOPHY AND BELIEFS

IN THIS SECTION, WE WANT TO UNDERSTAND THE PHILOSOPHY AND BELIEF SYSTEMS THAT HAVE GUIDED THE DEVELOPMENT AND IMPLEMENTATION OF YOUR PROJECT. WE WILL BE ASKING FOR YOUR VIEWS ON HOW SUBSTANCE ABUSE DEVELOPS IN INDIAN AND NATIVE COMMUNITIES, HOW INDIVIDUALS AND COMMUNITIES ARE PROTECTED FROM THE DEVELOPMENT OF SUBSTANCE ABUSE, AND WHAT IS THE BEST WAY FOR INDIAN AND NATIVE COMMUNITIES TO MAKE THE CHANGE TOWARD HEALTH.

1. **Factors Which Place An Indian Person At Risk for Substance Abuse/ Dependency:**

From your experience in Indian and Native communities, how significant do you think the following factors are in placing an Indian person at risk for substance abuse/dependence? Using the scale below, please circle the number to the right of each factor that best describes your belief.

	1 Not Significant	2 Somewhat Significant	3 Moderately Significant	4 Greatly Significant
History of:				
—multiple home placements:	1	2	3	4
—previous suicide threat or attempt:	1	2	3	4
—abuse/neglect:	1	2	3	4
—sexual abuse as child:	1	2	3	4
—recent death of relative or friend:	1	2	3	4
—poor academic performance:	1	2	3	4
—physical handicap/illness:	1	2	3	4
—negative boarding schoolexperience:	1	2	3	4
—family disruption or conflict:	1	2	3	4
—poor and inconsistent family management practices:	1	2	3	4
—parental divorce:	1	2	3	4
—parental alcoholism:	1	2	3	4
—person's early substance use:	1	2	3	4
—emotional/psychological difficulties:	1	2	3	4
—delinquency/crime:	1	2	3	4
—criminal behavior in parents or siblings:	1	2	3	4
—personal physical assault:	1	2	3	4
—substance use by friends and peers:	1	2	3	4
—school drop out:	1	2	3	4
—high absenteeism:	1	2	3	4
—poor self esteem:	1	2	3	4
—poor or undefined racial identity:	1	2	3	4
—poor relationships with family members:	1	2	3	4
—low socioeconomic background:	1	2	3	4
—low commitment to education:	1	2	3	4
—alienation from social values of White culture:	1	2	3	4
—alienation from social values of Indian culture:	1	2	3	4

	1 Not Significant	2 Somewhat Significant	3 Moderately Significant	4 Greatly Significant
—lack of attachment to neighborhood:	1	2	3	4
—community disorgan ization:	1	2	3	4
—frequent moves (residential mobility):	1	2	3	4
—depressed autonomic & central nervous system arousal:	1	2	3	4
—attention deficit disorder & hyperactivity:	1	2	3	4
—inability to metabolize alcohol efficiently:	1	2	3	4
—sensation seeking:	1	2	3	4
—risk taking:	1	2	3	4
—inadequate healthy recreational activities:	1	2	3	4
—high unemployment in community:	1	2	3	4
—cognitive deficits:	1	2	3	4
—other (specify): ______________________				
______________________________				
______________________________	1	2	3	4

2. Protective Factors:

From your experience in Indian and Native communities, how significant do you think the following factors are in protecting an Indian person from the negative effects of substance abuse/dependence? Using the scale below, please circle the number to the right of each factor that best describes your belief.

	1 Not Significant	2 Somewhat Significant	3 Moderately Significant	4 Greatly Significant
A. Personal Factors:				
—Person holds strong, positive values for academic achievement:	1	2	3	4
—Person is able to act independently when appropriate:	1	2	3	4
—Person is able to know when it is appropriate to depend on others:	1	2	3	4
—Person has a defined religious or spiritual belief system:	1	2	3	4
—Person acts according to healthy social norms:	1	2	3	4
—Person has positive self-esteem:	1	2	3	4
—Person is able to make decisions based on internal beliefs:	1	2	3	4
—Person has a strong commitment to doing what is correct and appropriate:	1	2	3	4
—Person values positive relationships with others:	1	2	3	4
—Other (specify): ______________________				
______________________________	1	2	3	4

	1 Not Significant	2 Somewhat Significant	3 Moderately Significant	4 Greatly Significant
B. Environmental Factors:				
—Person perceives he/she has respect and support from parent(s):	1	2	3	4
—Parent's value system is clearly & consistently communicated:	1	2	3	4
—Parent clearly and consistently set limits for child's behavior:	1	2	3	4
—Parent models appropriate and healthy behavior:	1	2	3	4
—Friends/peers model appropriate and healthy behavior:	1	2	3	4
—Parent demonstrates positive interpersonal skills:	1	2	3	4
—Friends/peers demonstrate positive interpersonal skills:	1	2	3	4
—Society's expectations for healthy & appropriate behavior are clearly communicated:	1	2	3	4
—Other (Specify): ____________________ ____________________ ____________________	1	2	3	4

3. **Philosophical Influences.** To what degree have the following concepts or approaches influenced the development of your project's philosophy about how to change self-destructive behavior and attitudes? Please circle the number associated with the phrase that best describes your answer.

CHILDREN OF ALCOHOLICS:

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

THE 12-STEP TRADITION (AA, NA, ALANON, ETC.):

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

FOUR WORLDS (UNIV. OF LETHBRIDGE, ALBERTA, CANADA):

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

ALKALAI LAKE (BRITISH COLOMBIA):

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

THE RED ROAD (VERMILLION, S.DAKOTA):

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

LOCAL TRIBAL BELIEFS:

1	2	3	4
No Influence	Little Influence	Moderate Influence	Substantial Influence

0 = Never heard of

4. **Intervention Goals**: The following list contains general goals that are articulated by many prevention projects. Please check all the goals that apply to your project's mission statement.

☐ Promoting mental health
☐ Promoting physical health
☐ Influencing legislative actions
☐ Improving socioeconomic situation
☐ Recognizing risk factors
☐ Limiting access to means of self-harm
☐ Alleviating situations of risk
☐ Improving educational opportunities
☐ Increasing/enhancing program or community resources
☐ Promoting cultural identity
☐ Integrating family into client's treatment
☐ Other(Specify):______________________________

II. DESCRIPTION OF PROJECT CHARACTERISTICS

IN THIS SECTION, WE WANT TO KNOW SOME OF THE OVERALL CHARACTERISTICS OF YOUR PROJECT. SPECIFICALLY, WE WILL BE ASKING YOU TO DESCRIBE THE PROVIDERS WHO ARE DELIVERING THE PREVENTION SERVICES OF YOUR PROJECT, TO WHOM THE SERVICES ARE DIRECTED (THIS GROUP WILL BE REFERRED TO AS THE "TARGET POPULATION"), AND IN WHAT CONTEXT THE SERVICES ARE OFFERED (WHEN AND WHERE).

5. **Project Responsibility:** Who is primarily responsible for implementing your prevention project? Please check appropriate box(es).

- ☐ Tribe
- ☐ State
- ☐ IHS
- ☐ BIA
- ☐ Other federal agency
- ☐ Private/nonprofit corporation
- ☐ Municipality/City or County
- ☐ Other(Specify):

6. **In Addition to OSAP Funds**: Check other funding sources.

- ☐ Tribe
- ☐ State
- ☐ IHS
- ☐ Other(Specify):
- ☐ Other federal agency
- ☐ Private foundation
- ☐ Program revenues/insurance company

7. **Setting of Prevention Activities:** Please check appropriate box(es).

- ☐ Home

School:
- ☐ a. Preschool
- ☐ b. Elementary
- ☐ c. Jr. High
- ☐ d. Sr. High
- ☐ e. Community College
- ☐ f. 4 Year College

Human service agency:
- ☐ a. Child welfare agency
- ☐ b. Court/Legal agency
- ☐ c. Other(Specify):

Outpatient Clinic:
- ☐ a. Medical health clinic/program
- ☐ b. Substance abuse clinic/program
- ☐ c. Mental health clinic/program

- ☐ Hospital
- ☐ Community (Specify): ______________________________
- ☐ Other (Specify): ______________________________

8. **Duration**: Please check the box(es) below that best describe the length of your prevention activities.

- ☐ Crisis only
- ☐ Predetermined number of sessions/classes (number = ____)
- ☐ Indeterminate number of sessions/classes

9. **Schedule**: Time of the day and week that prevention activities are offered: Please check appropriate box(es).

☐ Daytime, weekdays
Hours:______________
☐ Evening, weekdays
Hours:______________
☐ Night, weekdays
Hours:______________

☐ Day time, weekends
Hours:______________
☐ Evening, weekends
Hours:______________
☐ Night, weekends
Hours:______________

10. **Languages Utilized in Program Activities**: Please estimate the percentage of time in which the following languages are used in your project and indicate your answer on the graph below each language group.

English Language:

0 10 20 30 40 50 60 70 80 90 100%

Indian/Native Language:

0 10 20 30 40 50 60 70 80 90 100%

Other Language (i.e., Spanish, Chinese, etc.):

0 10 20 30 40 50 60 70 80 90 100%

Target Population: Please think about the people for whom your intervention activities are directed and check all the descriptors below that apply to them.

11. **Sex:** ☐ Male ☐ Female

12. **Age:**
- ☐ Infants (0-3 years)
- ☐ Preschool (4-5 years)
- ☐ School (6-12 years)
- ☐ Adolescents (13-19 years)
- ☐ Young adults (20-35)
- ☐ Middle-age adults (36-55)
- ☐ Elders (56 and older)

13. **Ethnicity of Your Target Population**: Please estimate the percentages which describe the ethnic categories of your target population and indicate on the graph below:

American Indian/Alaska Native:

0 10 20 30 40 50 60 70 80 90 100%

List major tribes represented: ______________________________
____

Other Minority, Non-Indian (i.e., Black, Asian, or Hispanic):

0 10 20 30 40 50 60 70 80 90 100%

Non-Indian:

0 10 20 30 40 50 60 70 80 90 100%

14. **Residential Status of Your Target Indian Population:** Please estimate the percentage of the Indian population whose residential status falls in the following categories below and indicate on the graph below:

Indian persons who primarily live on a reservation or in an Indian/Native community:

0 10 20 30 40 50 60 70 80 90 100%

Indian persons who primarily live in an urban setting:

0 10 20 30 40 50 60 70 80 90 100%

Indian persons who migrate between Indian reservation/community and urban setting:

0 10 20 30 40 50 60 70 80 90 100%

15. **Referral Mechanism**: How are participants referred to you? Please check all that apply.

☐ Self referral
☐ Family referral
☐ Other agency:
☐ Court referral
☐ In-house referral
☐ Other(Specify):____________________

16. **Number of Participants:** Please supply the number that best answers the following questions:

What is the current number of participants in your project? __________

What is the total number of participants since the beginning of your project? _______

Provider Characteristics

Please think of the people who deliver the prevention services in your communities. These providers may be volunteers from your communities and/or salaried workers paid from OSAP or other funding sources.

17. **Employment Status**: How many of the individuals who provide services of your prevention program fall in the categories below?

_____ Full-time paid staff + _____ Part-time paid staff = TOTAL _____
_____ Full-time volunteers + _____ Part-time volunteers = TOTAL _____

18. **Sex and Age**: How many of the individuals who provide services for your prevention program (both paid and volunteer providers) fall in the categories below?

Male		Female		
_____		_____		Adolescents (13-19 yrs old)
_____		_____		Young adults (20-35 yrs old)
_____		_____		Middle-age adults (36-55 yrs old)
_____		_____		Elders (56 yrs or older)
_____	+	_____	=	Total _____

19. **Educational Characteristics**: How many of the paid providers have achieved the following levels of formal education?

_____ High school or less
_____ College, partial or AA
_____ College, BA/BS/BSW
_____ Graduate School, MA/MS/MSW
_____ Graduate School, MD/PHD/EDD
_____ Specialized training (please specify)
____

20. **Ethnicity**: How many of your providers identify with the following ethnic categories?

Paid	Volunteer	
_____	_____	American Indian/Alaska Native
_____	_____	Other Minority, Non-Indian, (Black, Asian, Hispanic)
_____	_____	Non-Indian
_____	_____	Totals

III. DESCRIPTION OF SPECIFIC PROJECT STRATEGIES

WHEREAS, YOUR ANSWERS TO THE PREVIOUS SECTION DEALT WITH "WHO, WHEN & WHERE" QUESTIONS, THE FOLLOWING SECTION FOCUSES ON "WHAT AND HOW" QUESTIONS. SPECIFICALLY, WHAT ARE YOUR INTERVENTIONS AND HOW CAN WE BETTER UNDERSTAND HOW YOU DEVELOPED THOSE PARTICULAR ACTIVITIES FOR YOUR COMMUNITIES?

21. **Family Involvement**. To what extent is your project designed to involve families? Please circle the number over the phrase that best describes that involvement.

1	2	3	4	5
No Involvement	Some Involvement	Moderate Involvement	Great Involvement	Exclusive Involvement

Please give examples: ______________________________

____

____

22. **Community Involvement**. To what extent is your project designed to involve "the community"? Please circle the number over the phrase that best describes your project's involvement with community systems.

1	2	3	4	5
No Involvement	Some Involvement	Moderate Involvement	Great Involvement	Exclusive Involvement

Please give examples: ______________________________

____

____

23. **Cultural Involvement**. To what extent is your project designed to involve aspects of Indian/Native culture? Please circle the number above the phrase that best describes your involvement with Indian and Native culture.

1	2	3	4	5
A very little extent	A little extent	Some extent	A great extent	A very great extent

Please give examples: ______________________________

____

____

24. **Type of Intervention That Is School-Based**: Check all that apply to your project.

- [ ] No school-based intervention
- [ ] Referral for counseling/psychotherapy
- [ ] Individual counseling/psychotherapy
- [ ] Group counseling/psychotherapy
- [ ] Self-help groups (e.g., AA, ALATEEN, etc.)
- [ ] Social action groups (e.g., Students Against Drunk Driving)
- [ ] Special register (e.g., suicide register)
- [ ] Education/training using established curriculum (e.g., Here's Looking at You, Sacred Tree, driver education, etc.)
- [ ] Education/training not using established curriculum (e.g., special topic workshops, lectures, etc.)
- [ ] Legal intervention (e.g., banning sale of glue to minors)
- [ ] Recreational activities (e.g., Outward Bound, Run For Sobriety, etc.)
- [ ] Cultural activities (e.g., spirit camp)
- [ ] Special facility (e.g., medical holding room; foster care; detox center; shelter)
- [ ] Case/program consultation
- [ ] Other (Specify): ____
  ____

25. **Type of Intervention That Is Community-Based**: Check all that apply to your project.

- [ ] No community-based intervention
- [ ] Referral for counseling/psychotherapy
- [ ] Individual counseling/psychotherapy
- [ ] Group counseling/psychotherapy
- [ ] Self-help groups (e.g., AA, ALANON, etc.)
- [ ] Social action groups (e.g., Mothers Against Drunk Driving)
- [ ] Special register (e.g., suicide register)
- [ ] Education/training using established curriculum (e.g., Chemical People, Sacred Tree, driver education, etc.)
- [ ] Education/training not using established curriculum (e.g., special topic workshops, lectures, etc.)
- [ ] Legal intervention (e.g., banning sale of glue to minors)
- [ ] Recreational activities (e.g., Outward Bound, Run For Sobriety, etc.)
- [ ] Cultural activities (e.g., spirit camp)
- [ ] Special facility (e.g., medical holding room; foster care; detox center; shelter)
- [ ] Case/program consultation
- [ ] Other (Specify): ____
  ____

26. **Types of Curriculum Used**: From the following list of commonly used curriculum in schools and communities, please check those which are in use by your project.

a. ☐ BEGINNING ALCOHOL AND ADDICTIONS BASIC EDUCATION STUDIES (BABES):

______ Number of sessions
______ Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? ☐ YES ☐ NO

If yes, please describe the modification:

____
____

b. ☐ PROJECT CHARLIE:

______Number of sessions
______Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? ☐ YES ☐ NO

If yes, please describe the modification:

____
____

c. ☐ DARE TO BE YOU:

______Number of sessions
______Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? ☐ YES ☐ NO

If yes, please describe the modification:

____
____

d. [ ] HERE'S LOOKING AT YOU, 2000:

______ Number of sessions
______ Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____

____

e. [ ] TESTING REALITIES AND INVESTIGATING LIFE STYLES (TRAILS):

______ Number of sessions
______ Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____

____

f. [ ] CHEMICAL PEOPLE:

______ Number of sessions
______ Number of participants

Frequency: ______ Weekly
______ Bi-monthly
______ Monthly
______ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____

____

g. [ ] CIRCLE OF LIFE (MICHIGAN):

______Number of sessions
______Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

h. [ ] CHILDREN ARE PEOPLE, INC.:

______Number of sessions
______Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

i. [ ] PARENT EFFECTIVENESS TRAINING:

______Number of sessions
______Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

j. [ ] POSITIVE INDIAN PARENTING: HONORING OUR CHILDREN BY HONORING OUR TRADITIONS:

______ Number of sessions
______ Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____
____

k. [ ] WALKING WITH GRANDFATHER AND GREAT WOLF AND LITTLE MOUSE SISTER (FOUR WORLDS DEVELOPMENT PROJECT):

______ Number of sessions
______ Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____
____

l. [ ] THE SACRED TREE (FOUR WORLDS DEVELOPMENT PROJECT):

______ Number of sessions
______ Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____
____

m. [ ] OTHER (PLEASE SPECIFY):

______Number of sessions
______Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____
____

n. [ ] OTHER (PLEASE SPECIFY):

______Number of sessions
______Number of participants

Frequency: _____ Weekly
_____ Bi-monthly
_____ Monthly
_____ Other

Has this curriculum been modified in any way for your target population? [ ] YES [ ] NO

If yes, please describe the modification:

____
____

IV. ORGANIZATIONAL STRUCTURE AND MANAGEMENT

IN THIS SECTION, WE WOULD LIKE TO KNOW WHO ASSISTED YOU IN THE FOUR STAGES OF DEVELOPING YOUR PROJECT: THE PLANNING STAGE, THE OUTREACH AND RECRUITMENT STAGE, THE IMPLEMENTATION STAGE, AND THE EVALUATION STAGE. WE ARE INTERESTED IN DISCOVERING WHO IN YOUR COMMUNITIES COULD HAVE BEEN A PARTICIPANT, WHO SHOULD HAVE BEEN A PARTICIPANT, AND WHO ACTUALLY PARTICIPATED IN THE STAGES. IN ADDITION, WE WOULD LIKE TO KNOW HOW YOUR PROJECT IS ORGANIZED AND MANAGED.

27. Planning Stage: We want you to focus on the planning stage of your project.

a. Length of Planning Stage: Since the inception of your project, how many months have you spent in planning activities?

______ Months

b. Participants in Planning Stage: For each possible representative below, please circle the one (1) if that representative could have been available (i.e., the representative is available in your community to be involved in this stage).

Circle two (2) if the representative should have been involved (i.e., the representative is available in your community but for some reason or another, was not a participant in this stage).

Circle three (3) if that representative was actually involved (i.e., the representative is available in your community and did participate).

	Could have been involved	Should have been involved	Actually was involved
Representatives from:			
—Substance Abuse Program	1	2	3
—Mental Health Program	1	2	3
—Social Services Program (i.e., ICW)	1	2	3
—Medical Clinic or Hospital	1	2	3
—Schools (Head Start-High School)	1	2	3
—Colleges/Universities	1	2	3
—Johnson O'Malley Program	1	2	3
—Job Corps	1	2	3
—Parent Groups (i.e., PTA)	1	2	3
—Self-Help Group (AA, etc.)	1	2	3
—Courts	1	2	3
—Churches	1	2	3
—Tribal Council	1	2	3
—City Council	1	2	3
—County Government	1	2	3
—State Government	1	2	3
—Adolescent Population	1	2	3
—Adult Population	1	2	3
—Elder Population	1	2	3
—Vocational Rehabilitation	1	2	3

c. For those situations above in which a representative from a community sector was available but not involved, (should have been involved), please state why. ___________

____

28. **Outreach/Recruitment Stage**: Please think about the period in which your goal was to identify and attract potential project participants from your target population.

a. Length of Outreach/Recruitment Stage: Since the inception of your project, how many months have you spent in outreach and recruitment activities?
______ Months

b. Participants in Outreach/Recruitment Stage: For each possible representative below, please circle the one (1) if that representative could have been available (i.e., the representative is available in your community to be involved in this stage).

Circle two (2) if the representative should have been involved (i.e., the representative is available in your community but for some reason or another, was not a participant in this stage).

Circle three (3) if that representative was actually involved (i.e., the representative is available in your community and did participate).

	Could have been involved	Should have been involved	Actually was involved
Representatives from:			
—Substance Abuse Program	1	2	3
—Mental Health Program	1	2	3
—Social Services Program (i.e., ICW)	1	2	3
—Medical Clinic or Hospital	1	2	3
—Schools (Head Start-High School)	1	2	3
—Colleges/Universities	1	2	3
—Johnson O'Malley Program	1	2	3
—Job Corps	1	2	3
—Parent Groups (i.e., PTA)	1	2	3
—Self-Help Group (AA, etc.)	1	2	3
—Courts	1	2	3
—Churches	1	2	3
—Tribal Council	1	2	3
—City Council	1	2	3
—County Government	1	2	3
—State Government	1	2	3
—Adolescent Population	1	2	3
—Adult Population	1	2	3
—Elder Population	1	2	3
—Vocational Rehabilitation	1	2	3

c. For those situations above in which a representative from a community sector was available but not involved, (should have been involved), please state why. ___________

____

29. Project Implementation Stage: Please think about the implementing period of your project in which representatives from your community organizations were involved.

a. Length of Project Implementation Stage: Since the inception of your project, how many months have you spent in implementing the project's prevention activities?
_____ Months

b. Participants in Implementation Stage: For each possible representative below, please circle the one (1) if that representative could have been available (i.e., the representative is available in your community to be involved in this stage).

Circle two (2) if the representative should have been involved (i.e., the representative is available in your community but for some reason or another, was not a participant in this stage).

Circle three (3) if that representative was actually involved (i.e., the representative is available in your community and did participate).

	Could have been involved	Should have been involved	Actually was involved
Representatives from:			
—Substance Abuse Program	1	2	3
—Mental Health Program	1	2	3
—Social Services Program (i.e., ICW)	1	2	3
—Medical Clinic or Hospital	1	2	3
—Schools (Head Start-High School)	1	2	3
—Colleges/Universities	1	2	3
—Johnson O'Malley Program	1	2	3
—Job Corps	1	2	3
—Parent Groups (i.e., PTA)	1	2	3
—Self-Help Group (AA, etc.)	1	2	3
—Courts	1	2	3
—Churches	1	2	3
—Tribal Council	1	2	3
—City Council	1	2	3
—County Government	1	2	3
—State Government	1	2	3
—Adolescent Population	1	2	3
—Adult Population	1	2	3
—Elder Population	1	2	3
—Vocational Rehabilitation	1	2	3

c. For those situations above in which a representative from a community sector was available but not involved, (should have been involved), please state why.__________

____

30. **Evaluation Stage**: Please think about the period in which representatives from your community were involved with this stage.

a. Length of Evaluation Stage: Since the inception of your project, how many months have you spent in evaluation activities?

_____ Months

b. Participants in Evaluation Stage: For each possible representative below, please circle the one (1) if that representative could have been available (i.e., the representative is available in your community to be involved in this stage).

Circle two (2) if the representative should have been involved (i.e., the representative is available in your community but for some reason or another, was not participant in this stage).

Circle three (3) if that representative was actually involved (i.e., the representative is available in your community and did participate).

	Could have been involved	Should have been involved	Actually was involved
Representatives from:			
—Substance Abuse Program	1	2	3
—Mental Health Program	1	2	3
—Social Services Program (i.e., ICW)	1	2	3
—Medical Clinic or Hospital	1	2	3
—Schools (Head Start-High School)	1	2	3
—Colleges/Universities	1	2	3
—Johnson O'Malley Program	1	2	3
—Job Corps	1	2	3
—Parent Groups (i.e., PTA)	1	2	3
—Self-Help Group (AA, etc.)	1	2	3
—Courts	1	2	3
—Churches	1	2	3
—Tribal Council	1	2	3
—City Council	1	2	3
—Vocational Rehabilitation	1	2	3
—County Government	1	2	3
—State Government	1	2	3
—Adolescent Population	1	2	3
—Adult Population	1	2	3
—Elder Population	1	2	3
—Vocational Rehabilitation	1	2	3

c. For those situations above in which a representative from a community sector was available but not involved, (should have been involved), please state why. __________

____

31. **Administrative Characteristics of Project:** How true are the following statements about the administrative aspects of your project? Using the scale below, please circle the number to the right of each statement that best describes your belief.

1 Not Descriptive At All	2 Somewhat Descriptive	3 Moderately Descriptive	4 Very Descriptive	5 Perfectly Descriptive

—The cost of our project is understood.	1	2	3	4	5
—Materials needed to perform the job are available.	1	2	3	4	5
—Clearly stated goals and objectives for the program are available	1	2	3	4	5
—Action plans needed to meet the objectives are understood and followed.	1	2	3	4	5
—The amount of work each person must do to meet schedule is understood by all the people in our project.	1	2	3	4	5
—The layout or arrangement of our office or work space helps us to get our job done.	1	2	3	4	5
—Support people such as secretaries, receptionists, and supply clerks help us get the job done.	1	2	3	4	5
—Changes in methods of doing the job are madeeffectively.	1	2	3	4	5
—Everyone helps set goals for the project.	1	2	3	4	5
—Employees have plenty of freedom on the job to use their own judgement.	1	2	3	4	5
—Outstanding performers are given special recognition for their contributions.	1	2	3	4	5
—Achievement is a source of individual gratification. Results are attained because people are committed to getting them, not because they are pushed.	1	2	3	4	5
—Outstanding performers are usually given the opportunity to handle more responsible jobs.	1	2	3	4	5
—Supervisors feel a responsibility to help individuals develop and grow with the organization.	1	2	3	4	5
—Employees know how their work fits in with other functions to attain the overall project objectives.	1	2	3	4	5
—Outstanding performers are recognized by levels above their immediate bosses, because supervisors keep their superiors fully informed of key contributors.	1	2	3	4	5

Organizational and Performance Characteristics:

32. **Leadership Processes Used**: What follows are characteristics describing how a project can be organized and managed. For each set of characteristics, please circle the number above the statement that best describes how your organization operates.

a. Extent to which supervisors have confidence and trust in staff.

1	2	3	4
Extent to which you have trust in staff	Extent to which you have condescending confidence & trust such as master has to servant	Extent to which you have substantial but not complete confidence & trust; still wishes to keep control of decisions	Extent to which you have complete confidence & trust in all matters

b. Extent to which immediate supervisor in solving job problems generally tries to get staff ideas and opinions and make constructive use of them.

1	2	3	4
You seldom get ideas & opinions from staff in solving job problems	You sometimes get ideas & opinions fromstaff in solving job problems	You usually get ideas & opinions and usually try to make constructive use of them	You always get ideas & opinions and always try to make contive use of them

33. **Character of Motivational Forces:**

a. Manner in which motives are used.

1	2	3	4
Fears, threats, punishment, & occasional rewards	Rewards & some actual or potential punishment	Rewards, occasional punishment, & some involvement	Economic rewards based on compensation system developed through participation; group participation & involvement in setting goals, improving methods, appraising progress toward goals, etc.

b. Amount of responsibility felt by each member of project for achieving project's goals.

1	2	3	4
High levels of management feel less; rank and file feel little and often welcome opportunity to behave in ways defeat organization's goals	Managerial personnel usually feel responsibility; rank and file usually feel relatively little responsibility for achieving organization's goals	Substantial proportion of personnel, especially at high levels, feel responsibility and generally behave in ways to achieve the organization's goals	Personnel at all levels feel real responsibility for organization's goals and behave in way to implement them

34. Character of Communication Process:

a. Direction of information flow. In this section we would like to know how information and communication is processed.

1	2	3	4
Downward	Mostly Downward	Down & up	Down, up, & with peers

b. Extent to which downward communications are accepted by staff.

1	2	3	4
Viewed with great suspicion	May or may not viewed with suspicion	Often accepted but at times view with suspicion; may or or may not be openly questioned	Generally accepted, but if not, openly and candidly questioned

c. Accuracy of upward communication from project staff to you.

1	2	3	4
Tends to be inaccurate	Information that boss wants to hear flows; other information is restricted and filtered	Information that boss wants to hear flows; other information may be limited or cautiously given	Accurate

d. Psychological closeness of supervisors to staff (e.g., How well do you know and understand problems faced by project staff?)

1	2	3	4
Has no knowledge or understanding of problems of staff	Has some knowledge and understanding of problems of staff	Knows and understands problems of staff quite staff	Knows and understands problems of staff very well

35. Character of Interaction-Influence Process:

a. Amount of cooperative teamwork present.

1	2	3	4
None	Relatively little	A moderate amount	Very substantial amount throughout the organization

36. Character of Decision-Making Process:

a. At what level in project organization are decisions formally made?

1	2	3	4
Bulk of decisions at top of organization	Policy at top, many decisions within prescribed framework made at lower levels	Broad policy and general decisions at top, more specific decisions at lower levels	Decision making widely done throughout organization, although well integrated through linking process provided overlapping group

b. To what extent are decision makers aware of problems, particularly those at lower levels in the project organization?

1	2	3	4
Often are unaware or partially aware	Aware of some, unaware of others	Moderately aware of problems	Generally quite well aware of problems

c. To what extent are staff involved in decisions related to their work?

1	2	3	4
Not at all	Never involved in decisions; occasionally consulted	Usually are consulted but ordinarily not involved in the decision making	Are involved fully in all decisions related to their work

37. **Character of Goal Setting or Ordering:**

a. Manner in which usually done

1	2	3	4
Orders issued	Orders issued, opportunity to comment may or may not exist	Goals are set or orders issued after discussion with staff of problems and planned action	Except in emergencies, goals are usually established by means of group participation

b. Are there forces to accept, resist, or reject goals?

1	2	3	4
Goals are overtly accepted but are covertly resisted strongly	Goals are overtly accepted but often covertly resisted to at least a moderate degree	Goals are overtly accepted but at times with some covert resistance	Goals are fully accepted both overtly and and covertly

38. **Characteristics of Control Process:**

a. Extent to which the review and control functions are concentrated.

1	2	3	4
Highly concentrated in top management	Relatively highly concentrated, with some delegated control to middle and lower levels	Moderate downward delegation of review and and control processes; lower as well as higher levels feel responsible	Quite widespread responsibility for review and control, with lower units at times imposing more rigorous reviews and tighter controls than top management

b. Extent to which there is an informal organization present and supporting or opposing goals of formal organization.

1	2	3	4
Informal organization present and opposing goals of formal organization	Informal organization usually present and partially resisting goals	Informal organization may be present and may either support or partially resist goals of formal organization	Informal and formal organization are one and the same; hence all social forces support efforts to achieve organization's goals

V. PROJECT EVALUATION

IN THIS SECTION WE WILL BE ASKING YOU TO ASSESS YOUR PROJECT'S EFFECTIVENESS AT THIS POINT IN TIME. ADDITIONALLY, WE WOULD LIKE YOU TO INFORM US ABOUT THE BARRIERS THAT HAVE COME UP DURING YOUR PROJECT'S LIFETIME AND TO LEARN YOUR IDEAS ABOUT HOW TO IMPROVE YOUR PROJECT'S IMPACT IN THE COMMUNITIES. LASTLY, WE ARE INTERESTED IN KNOWING HOW YOU MEASURE CLIENT AND PROJECT OUTCOMES.

39. **Project Effectiveness:** On a scale of 1 to 7, ranging from not effective to extremely effective, circle the number that best describes how successful you believe your project to be.

1	2	3	4	5	6	7
Not Effective			Moderately Effective			Extremely Effective

40. **Barriers to Project Success:** Please think about the factors that may serve as barriers to your project's success. Circle the number to the right of each statement that best describes to what degree that factor is serving as a barrier in your intervention project.

	1 Not a Factor	2 Minor Factor	3 Moderate Factor	4 Large Factor
—Rivalry between tribes targeted for services:	1	2	3	4
—Political leadership is non-supportive and/or is negative:	1	2	3	4
—Political interference:	1	2	3	4
—More time is needed to educate key community leaders:	1	2	3	4
—Insufficient funds:	1	2	3	4
—Difficulty in employing qualified providers:	1	2	3	4
—Difficulty in employing qualified American Indian/Alaska Native providers.	1	2	3	4
—Disorganization in project's host agency:	1	2	3	4
—Personnel conflicts:	1	2	3	4
—Little or no community support:	1	2	3	4
—Laws that hinder prevention or treatment:	1	2	3	4
—Poor communication throughout project and/or host agency:	1	2	3	4
—Input from staff is not encouraged:	1	2	3	4
—Little or no support or positive feedback from management:	1	2	3	4
—Philosophy of project is unclear:	1	2	3	4
—Poor training:	1	2	3	4
—Little or no involvement with client's family:	1	2	3	4

	1 Not a Factor	2 Minor Factor	3 Moderate Factor	4 Large Factor
—Little or no support from client's family:	1	2	3	4
—Physical setting not adequate or appropriate:	1	2	3	4
—Racial tension between Indians and non-Indians:	1	2	3	4
—Other (please specify):				
____________________	1	2	3	4
____________________	1	2	3	4

41. **Ways to Improve Project**: How important do you believe the following actions would be to improving your project? Please circle the number at the right of each statement that best describes how important you believe that action is in improving your project.

	1 Not Important	2 Somewhat Important	3 Moderately Important	4 Greatly Important	5 All Important
—Implement better working relationship with client's family:	1	2	3	4	5
—Implement better working relationship with the community:	1	2	3	4	5
—Organize fundraisers, (i.e. raffles, etc.):	1	2	3	4	5
—Improve the relationship between tribes targeted for services:	1	2	3	4	5
—Improve training plan for providers of service:	1	2	3	4	5
—Provide sufficient time to explain project's philosophy to project staff:	1	2	3	4	5
—Provide sufficient time to explain project's philosophy to community:	1	2	3	4	5
—Broaden employee search to a wider area, i.e. regional or national:	1	2	3	4	5
—Organize extracurricular events for staff, i.e. teambuilding:	1	2	3	4	5
—Influence legislators to prohibit drinking on reservation/catchment area:	1	2	3	4	5
—Influence legislators to allow drinking on reservation:	1	2	3	4	5
—Influence legislators to increase drinking age to 21:	1	2	3	4	5
—Broaden key community leader's knowledge of project services:	1	2	3	4	5

	1 Not Important	2 Somewhat Important	3 Moderately Important	4 Greatly Important	5 All Important
—Implement program to improve relationships among staff:	1	2	3	4	5
—Implement special program to support open communication across all levels of project operations:	1	2	3	4	5
—Create a job training program for clients:	1	2	3	4	5
—Other (please specify):					
______________________________	1	2	3	4	5
______________________________	1	2	3	4	5

42. **Project Evaluation Designs**: Please mark the design that best fits your evaluation plan from the choices below:

a. Does your evaluation plan include:

- ☐ process evaluation only? (Process evaluation is a thorough description of the various aspects of a project: the target population, the personnel operating the project, the services delivered, and the utilization of resources for project components.)
- ☐ outcome evaluation only? (Outcome evaluation is an attempt to determine if the project has met its objectives in producing changes in perceptions, attitudes, behaviors, or other effectiveness indicators among its targeted client group.)
- ☐ both process and outcome evaluation?
- ☐ no evaluation plan?

b. Does your evaluation plan require:

- ☐ qualitative measures? (These are measures which reflect subjective value judgements about the nature of the intervention, i.e., a client reports that the intervention was "useful and fun".)
- ☐ quantitative measures? (These are measures which reflect numerical valuations about the nature of the intervention, i.e., the number of high school graduates.)
- ☐ both qualitative and quantitative measures?
- ☐ no evaluation measures?

c. Does your evaluation plan require:

- ☐ evaluation by individual(s) from within your host agency?
- ☐ evaluation by individual(s) from outside of your host agency?
- ☐ evaluation by individuals from both within and outside of your host agency?
- ☐ no evaluation plan?

43. Client Outcome Measures: How do you measure a client's successful completion of your project? From the following list of client outcome measures, please check those that are utilized in your project evaluation.

a. Changes in These Behaviors:

- ☐ Academic progress
- ☐ Fewer instances of acting out in school
- ☐ Less negative perceptions of school environment
- ☐ Interest in completing high school
- ☐ Interest in pursuing higher education
- ☐ Ability to form long or short term goals
- ☐ Gain in sense of personal control
- ☐ Reduction of depression, anxiety, fear, and feelings of inadequacy
- ☐ Improved self-perception
- ☐ Client feeling of ownership from community
- ☐ Positive peer interaction
- ☐ Positive family interaction
- ☐ Takes more attention to self-appearance
- ☐ Improved weight gain or weight loss
- ☐ Improved eating habits
- ☐ Overall health improvements
- ☐ Developed ways of spending time in a positive manner
- ☐ Acquired job skills
- ☐ Acquired skills to be a peer leader
- ☐ Acquired skills to develop mutual-help and self-help groups
- ☐ Reduced alcohol use
- ☐ Reduced alcohol abuse
- ☐ Other (specify):____________________________________

b. Changes in These Areas of Knowledge:

- ☐ History of substance abuse among American Indians/Alaska Natives
- ☐ Physical and emotional effects of alcohol/other substances
- ☐ Self-awareness and culture identity issues
- ☐ Values and attitude clarification
- ☐ Peer pressure and decision making
- ☐ Effective communication
- ☐ Family bonding and enrichment
- ☐ Risks to children of alcoholics
- ☐ Fetal Alcohol Syndrome prevention
- ☐ Effective parenting
- ☐ Awareness of community resources
- ☐ Single parenting activities
- ☐ Other (specify):____________________________________

44. **Project Outcome Measures**: How do you measure the overall outcomes of your project? From the following list, please check those project outcome measures that are utilized by your project.

- ☐ Number of clients that satisfactorily complete project
- ☐ Number of clients that unsatisfactorily complete project
- ☐ Good working relationship with staff and client
- ☐ Client not back in the juvenile system
- ☐ Project developed good relationship with client's family
- ☐ Good follow up project instituted
- ☐ Quick recovery time for client
- ☐ Creation of health promotion/disease prevention activities
- ☐ Increased participation in outreach projects
- ☐ Conducted workshops/training for community
- ☐ Reduced truancy
- ☐ Increased school attendance
- ☐ Decreased disciplinary problems
- ☐ Increased number of high school graduates
- ☐ Reduced fetal alcohol syndrome/effects
- ☐ Reduced alcohol/substance abuse

Reduced alcohol/substance abuse related:

  - ☐ Accidents
  - ☐ Arrests
  - ☐ Family violence
  - ☐ Child abuse/neglect
  - ☐ Teen-age pregnancy
  - ☐ Cirrhosis
  - ☐ Acute episodes of hospital/clinic admission
  - ☐ Homicide
  - ☐ Suicide
  - ☐ Trauma

- ☐ Other:

45. **Person to contact for more information about program:**

Name(s) ____________________

Title(s) ____________________

Mailing address ____________________

____________________ Phone(   ) ____________________

THANK YOU FOR YOUR PARTICIPATION!!

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